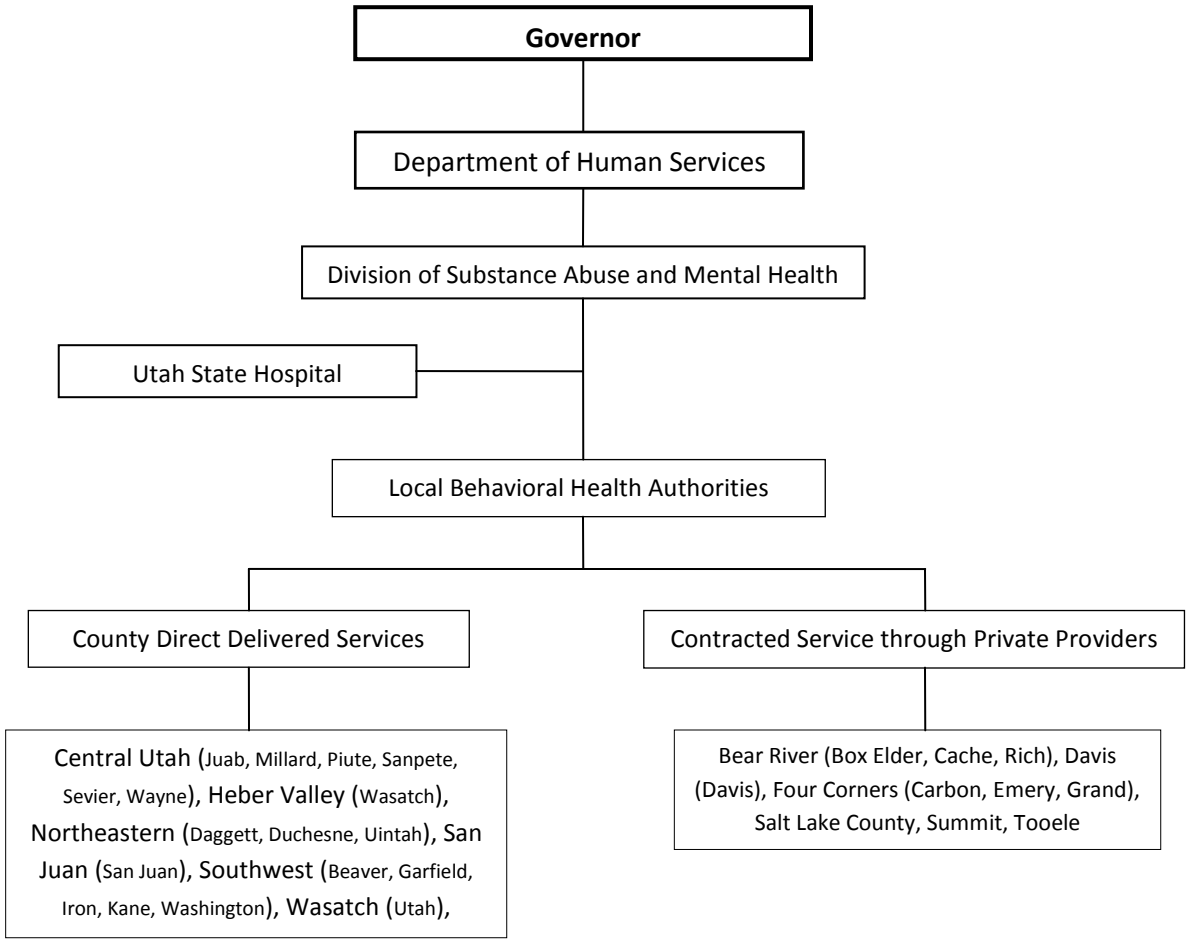
Section II – State Planning Steps

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

I. Overview of State Behavioral Health System



II. Organization of the Utah Public Behavioral Health System

a. State level organization—Utah Department of Human Services

The Department of Human Services Director is a member of the Governor's Cabinet Council along with all other department heads. The Department of Human Services is one of the largest departments in Utah's State government and consists of the following service offices and divisions:

- Division of Substance Abuse and Mental Health
- Division of Aging & Adult Services (programs supported under the Older Americans Act and Adult Protective Services)
- Division of Services for People with Disabilities (persons with developmental delays, mental retardation and traumatic brain injuries)
- Division of Child & Family Services (child welfare)
- Division of Juvenile Justice Services (youth corrections)
- Office of Recovery Services (child support enforcement)
- Office of Public Guardian (guardian/conservator services for vulnerable adults)
- Office of Licensing (for all public and private human service provider agencies within Utah)

Coordination is a major emphasis in the Department, and this is accomplished through several means. The various division and office directors meet monthly to discuss interagency issues and resolve interdepartmental conflicts.

Additionally there are numerous working groups and committees that meet to coordinate specific programs and initiatives that cross division and office boundaries.

b. Intermediate and local organization - Utah State Division of Substance Abuse and Mental Health and the local behavioral health authorities

The Utah Division of Substance Abuse and Mental Health (DSAMH) is authorized under Utah State Code Annotated §62A-15-103 as the single state authority for mental health and substance abuse in Utah. Utah Statutes require that the DSAMH "*… set policy for its operation and for programs funded with state and federal money…establish, by rule, minimum standards for local substance abuse authorities and local mental health authorities…develop program policies, standards, rules, and fee schedules for the division…"*(Utah Code Title 62A, Chapter 15, Section 105 "Authority and Responsibilities") and that the DSAMH "*…contract with local substance abuse authorities and local mental health authorities to provide a comprehensive*

continuum of services in accordance with division policy, contract provisions, and the local plan…" (Utah Code 62A-15-103. "Division -- Creation – Responsibilities").

The DSAMH carries out its statutory obligations by contracting with Local Substance Abuse and Mental Health Authorities for the delivery of Behavioral Health services. The DSAMH distributes federal and state funds through contracts, and monitors Local Authorities to ensure compliance with statutory mandates and contracted services. Contracting requirements, monitoring and oversight, rule writing, interagency coordination, and technical assistance are used to influence and guide systems of care. The DSAMH also provides leadership and coordination with other state agencies, the state legislature and advocacy groups.

The Director of the DSAMH serves as the SSA and SMHA, and as such oversees the provision of Behavioral Health Services in the State. The Director of the DSAMH is supported by an Assistant Director of Mental Health and an Assistant Director of Substance Abuse. Utah's DSAMH, and the Utah public behavioral health system operates under the official mission statement of "***Hope and Recovery"*** and we are guided by the following key principles:

Quality services, programs, and systems promote individual and community wellness.

Education enhances understanding of prevention and treatment of substance abuse services.

Leadership understands and meets the needs of consumers and families.

Partnerships with consumers, families, providers and local/state authorities are strong.

Accountability in services and systems that is performance focused and fiscally responsible.

Utah State Statute specifically mandates the Local Substance Abuse Authorities (LSAA) provide a "continuum of services for Adolescents and Adults" aimed at substance abuse prevention and treatment. It also requires Local Mental Health Authorities (LMHA) to provide ten mandatory services. Thus, Utah's Substance Abuse and Local Mental Health Authorities, under the direction of the County Governments, are given the responsibility to provide substance use disorder and mental health services to their citizens. Funding to provide required federal and state services is a combination of CMHS and SAPT block grant funds, State General Funds, County matching funds (20 percent), and other State and Federal funds. State and federal

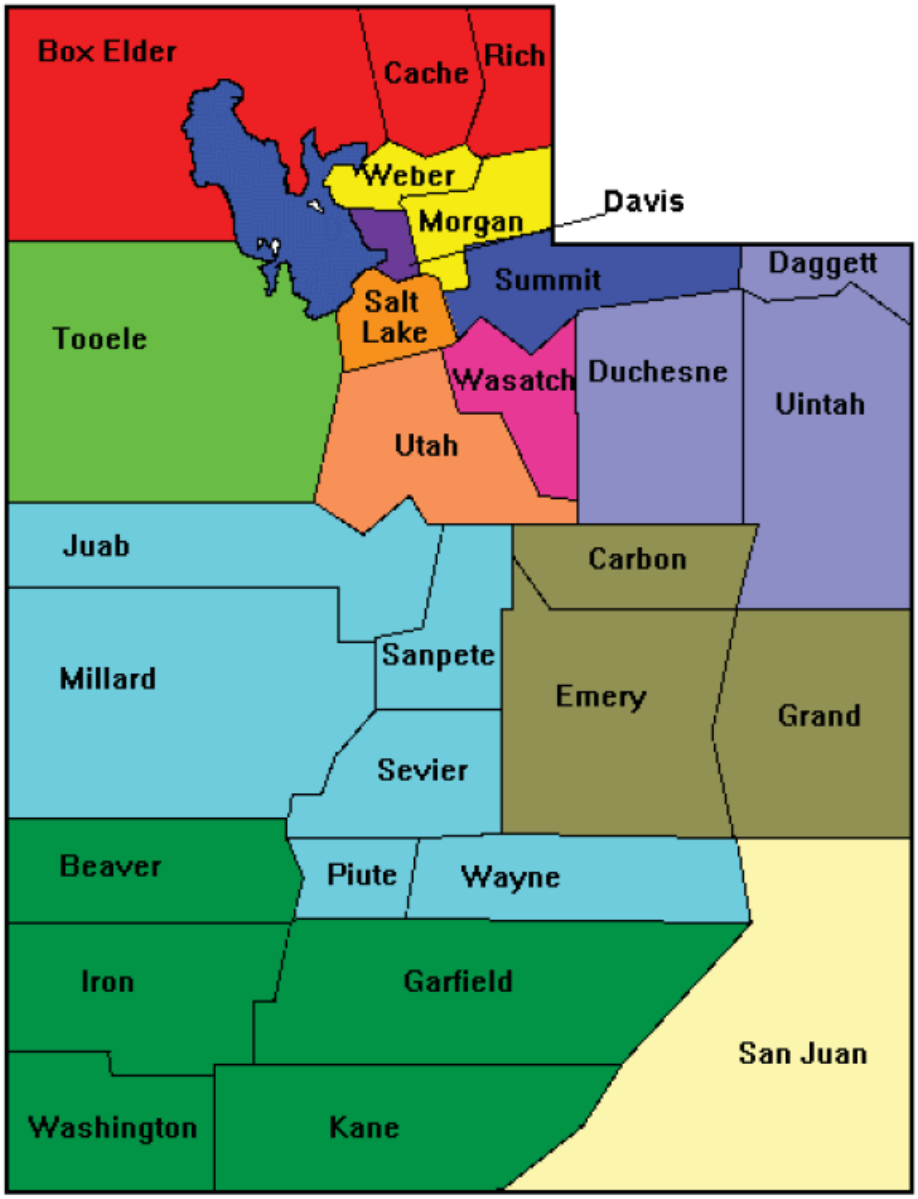
funds are allocated to Local Authorities through a formula which takes into account the percent of the state's population residing within the county's boundaries and a rural differential. Each county is required to provide at least a 20% match on all state general funds. The majority of general and county matching funds are used to meet Medicaid match requirements.

As authorized in statute, the 29 counties in Utah have organized themselves into 13 Local Authorities. (See attached diagram) Also by Statute, each local authority is statutorily required to submit an Area Plan annually that is approved by the DSAMH. Area Plans, submitted in May of each year, describe the Local Authority's plan to provide services for the coming Fiscal Year and how Federal and State requirements will be met. Plans are based on statutory requirements and a DSAMH Directive that is provided each year to the local authorities shortly after the Legislative Session ends in March. The current DSAMH Directives are located at: **http://www.dsamh.utah.gov**. Contracts with the Local Authorities and funding allocations are approved only after the Area Plans have been approved by the DSAMH Director. It should be noted that changes to State contracts require a minimum of four months lead time to ensure approval from the required reviewing authorities.

Area plans describing what services will be provided with state, federal and county funds are developed and submitted to the DSAMH. These become the foundation of contracts between the DSAMH and each of the Local Authorities. Utah's public Behavioral Health system for child, youth/adolescent and family services has the same organizational structure as the adult system. Local Authorities are required to outline in their area plan how they are planning to provide mental health and substance abuse treatment and prevention services to this population as well as the adult population.

Generally, a Local Substance abuse and/or Mental Health Authority is the governing body of a county (i.e. a commissioner or council member). Many counties have joined together under inter-local agreements to create a single Local Authority where one commissioner representing each county holds a seat on the governing board. Services are delivered through contracts with local providers, in most cases, a combined Community Substance Abuse and Mental Health Center, and in compliance with statue, administrative rule, and under the administrative direction of the DSAMH. In most areas short-term acute hospitalization is provided through contracts with local private hospitals. Local Authorities set the priorities to meet local needs, but at a minimum must provide ten mandated mental health services and substance use disorder services.

The ten mandated mental health and substance use disorder services a foundation for consumers who qualify for services to receive a large array of care options and treatment modalities. These mandated services are delivered in a non-linier way, meaning consumers receive only the services they need and want without being forced into a single point of entry, one size fits all system. Due to funding limitations, those who are not eligible for Medicaid do not generally have access to this full range of services.



The Utah State Hospital provides statewide inpatient mental health services. It is a 24-hour psychiatric facility located in Provo, Utah and is organized as a part of the DSAMH. The State Hospital currently provides active psychiatric treatment for 252 adult patients and has the capacity to provide active psychiatric treatment for 72 children. Patients must be actively experiencing symptoms of severe and persistent mental illness to qualify for services, and are placed through a civil commitment or forensic commitment. The State Hospital is accredited by the Joint Commission and certified for Medicare/Medicaid reimbursement by the Center for Medicare & Medicaid Services.

State statute allocates all pediatric and youth beds to the Local Mental Health Authorities, but the DSAMH is responsible for establishing a bed allocation formula, which is based on the percentage of state population within each Local Authority's catchment area and a rural differential. The Community Mental Health Centers monitor State Hospital treatment and provide follow-up care in the community.

III. Addressing the needs of Utah's diverse racial, ethnic and sexual gender minorities, youth and the underserved

One of greatest challenges to providing services to Utah residents is the distribution of the state's population. Utah is 84,900 square miles with urban, rural and frontier communities, and is currently one of the fastest growing states in the nation with population estimates to exceed 3.4 million persons by 2020. Utah is home to 5 federally recognized American Indian Tribes including the Ute, Navajo, Piute, Shoshone and Goshute people. Our state is increasingly diverse in culture—minority populations have increased from 2% to 20% of the total population during the past two decades and Utah's Hispanic population continues to be the fastest growing community in the state. Compared to national averages, our population is younger and lives longer, has a higher birth rate, and currently Utah averages the highest number of persons per household. Due to the expanse of rural and frontier regions throughout Utah, some counties have joined together to provide services for their residents. Consequently, there are 29 counties in Utah (including 19 rural classified counties), and 13 local behavioral health authorities. By legislative intent, with the exception of the Utah State Hospital, no substance abuse or community mental health center is operated by the State; the state does not provide clinical care for behavioral health.

Native American populations reside on tribal lands in the Northeastern and Southeastern regions of the state; Federal, State, County and Native American jurisdictions are involved in providing services to this population. Both of these areas are relatively remote with poor transportation and sparse populations, which further stretch the state's resources. The direct planning and provision of services is the responsibility

of the Local Authorities in those areas, and the provision of services to Native American populations is a part of the annual contract review and audit. Success in negotiating service agreements and coordinating services is often an issue of local politics and personalities. Utah's Department of Human Services has developed an intertribal council and signed a coordination/collaboration agreement with the various Native American tribal representatives supporting the need for planning and coordination at a state level.

According to the 2011 US Census, Utah's adult population is 1.9 million. The 2012 Utah Department of Health, CDC Behavioral Risk Factor Surveillance System Report (BRFFS) found that 22 percent of Utah's adult population suffers from a chronic health condition and high rates of co-occurring chronic physical and mental illness among Utah's adult population. This research indicates that adults with mental illness in Utah have an increased risk of having a co-occurring physical health condition. Similarly, it indicates that adults in Utah with a chronic health conditions are at increased risk of a co-occurring mental health condition. Currently, the Utah Division of Substance Abuse and Mental Health (DSAMH) are working with the Utah Department of Health to assess the need and capacity for programming and creating integrated solutions to support this population.

Much of the state of Utah is classified as either rural or frontier land. Populations in living in these areas face economic limitations and geographic challenges that limit access to resources, services, and opportunities. According to the USDA Economic Research Service, the average per-capita income for Utahans in 2009 was $31,584 although rural per-capita income lagged at $27,373. 2010 estimates indicate a poverty rate of 14.6% exists in rural Utah, compared to a 13.1% level in urban areas of the state. Data from 2010 US Census American Community Survey indicates rural populations have higher high school drop-out rates than urban populations (11.6% of the rural population has not completed high school, compared to 9.1% of urban populations). The unemployment rate in rural Utah is at 7.6%, while in urban Utah it is at 6.6% (USDA-ERS, 2011). Of twenty rural hospitals in the Utah, as of 2012, fourteen identified a "lack of access to mental health services" as the number one concern of their physicians and hospital administration.

Although a relatively low number of adults use tobacco in Utah (9.1% compared to the national average of 20.1%), a study by **The Journal of the American Medical Association** reported that 44.3 percent of all cigarettes in America are consumed by individuals who live with mental illness and/or substance abuse disorders. In Utah, sadly, we are at even greater risk than the national average: over 68% of individuals using tobacco has a diagnosed mental illness and/or substance use disorder (Utah Department of Health, 2010). In Utah, smoking claims the lives of more than 1,150 adults each year. We know smoking exacerbates or

causes nearly every chronic condition and contributes to Utah's primary causes of death including heart disease, respiratory disease, and cancer, especially in the disparate population of adults with serious mental illness.

According to the National Association of State Mental Health Program Directors, people with mental illness die 25 years earlier on average than the general population, largely due to conditions caused or worsened by smoking. Again, Utah has a higher rate than the national average with this identified population; in Utah, adults with serious mental illness die 27 years earlier on average than the general population. We have taken the need for tobacco-cessation seriously, three years ago we successfully developed statewide tobacco-free policy (Recovery Plus) to create tobacco-free environments and implement effective tobacco-cessation programming.

Suicide was the leading cause of injury-related death and the third leading cause of hospitalizations for all ages in Utah from 2008-2010. Suicide is the 2nd leading cause of death for Utah teens ages 15-19, and the 4th leading cause of death for Utah adults ages 20-64. On average:

- 22 Utah teens ages 15-19 die from suicide each year;
- two Utah teens ages 15-19 are treated in the emergency department or hospitalized every day because of suicide attempts;
- 319 Utah adults ages 20-64 die from suicide each year;
- eight Utahans 20-64 years of age are treated in the emergency department or hospitalized every day because of suicide attempts;
- 35 Utahans 65 years and older die from suicide each year; and
- 1 Utahan 65 years or older is treated in the emergency department or hospitalized every week because of a suicide attempt.

Utah's suicide rate has been consistently higher than the U.S. rate for the last decade. A recent CDC study found that Utah had the highest prevalence of suicidal thoughts among adults in the nation (U.S Surveillance Summaries, October 21, 2011 / 60(SS13); 1-22). Additionally, Utah has the 8th highest adult suicide rate in the U.S., the 12th highest teen suicide rate in the U.S., and the 14th highest older adult suicide rate in the U.S.

The 2009 Utah Disease/Risk Factor Integration Matrix, developed with support from the National Center for Health Statistics provided a grim report of the quality of life for individuals living with multiple chronic conditions in Utah. This report analyzed the prevalence of chronic diseases and chronic disease risk factors for the adults in Utah. It showed that Utahans who have a serious mental illness also have higher rates of arthritis, asthma, and hypertension that are significantly than the general population. Furthermore, adults with serious mental illness in Utah have excessively high rates of poor nutrition, smoking, obesity, and over 66 percent of this population does not engage in regular physical activity. In addition to the Wellness Directive implemented in 2005, which requires public behavioral healthcare providers to monitor weight and screen for primary health conditions such as diabetes, Utah is committed to making SAMHSA-HRSA's Whole Health Wellness and Resiliency model readily available to our local authorities throughout the state to support the development of integrated primary and behavioral health services. The Whole Health Wellness and Resiliency model is intended to provide person-centered goal setting support to consumers, primary care providers, and behavioral health providers as they develop treatment goals that address the "whole person" and promote prevention through resiliency.

DSAMH has numerous past successes in improving community outcomes, and we have learned a few lessons along the way too. One of the best recent examples is the Recovery Plus initiative, Utah's statewide policy to address the need for tobacco-cessation which has successfully created policy and programming to help people stop using tobacco. Utah now requires all campuses and treatment facilities to be smoke-free, has initiated tobacco-cessation coaching and the Utah Quit Net, and launched a successful awareness campaign to connect people with resources to stop using tobacco. Much of this work was accomplished in partnership with the Department of Health and with the support of the Local Authorities. Although there was some strong initial criticism of tobacco-free policy in the state, outcomes for tobacco cessation indicate that Recovery Plus is a strong and valuable program. Through partnership with Department of Health Leadership team, stigma and bias about smoking is being corrected through collaborative efforts with the media, policy change, and ongoing public awareness efforts.

Another promising example of past successes in improving community outcomes is the work DSAMH Prevention Specialists have engaged in with the Communities That Care Model, a coalition-based prevention operating system that uses a public health approach to prevent adverse experiences such as violence, delinquency, depression, anxiety, and substance abuse. Utah now has 17 communities using the CTC model and key findings indicate a significant reduction in youth substance use and delinquency. Trusting the past

success of the CTC model, the DSAMH mental health team, prevention team, and children youth and families team recently collaborated to create a shared funding opportunity for the local community to conduct a statewide data-driven needs and strengths assessment to support local authorities in developing key relationships to address the most urgent needs in their regions.

Tracking Progress in Treatment Goals

Measuring patient outcomes is essential to Utah's plan for transforming the public mental health care system. The implementation of science and progress in treatment is a priority. The Division requires all publicly funded community mental health and substance abuse providers to utilize a statewide system for assessing and measuring patient outcomes. OQ-HS® created by OQ Measures, automates the administration and reporting on the adult Outcome Questionnaire® (OQ®). This instrument is recognized as one of the leading outcome tracking methodologies for quantifying and evaluating the progress of behavioral health therapy, and has been widely adopted by a variety of behavioral and other health care service organizations. OQ Measures is working on an enhancement that will help track symptom relief and progress towards meeting person-centered planning objectives. Block Grant funds are planned to supplement this project which provides treatment providers, authorities, and administrators with an important tool for scientifically measuring progress towards recovery.

Step 3&4 Priority Area and Annual Performance Indicators

Steps 3&4

State Priority Goals

State Priority 1: Plan for and implement Health Care Reform (HCR).

Goal A: Improve coordination of Mental Health and Substance Abuse Services with other Human Service and Health Agencies and align services to provide for expanded use of Medicaid and private insurance.

Populations: All

Strategies:

1. Participate in all Legislative, Departmental, Provider Association and interagency Health Care Reform Committee meetings and initiatives.

2. Participate and provide leadership to Department of Human Services Committees and workgroups developing policy and procedures for integrating Behavioral Health care with other health care services.

3. Participate and provide leadership in legislative, Department of Health (DOH) and other partners and interagency workgroups revising Medicaid reimbursement plans and policies.

4. Participate in all SAMHSA meetings on Health Care Reform initiatives.

5. Provide recommendations to the Director of the Department of Human Services (DHS) on policy, statute and rule changes needed to prepare the DHS for implementation of Health Care

6. In coordination with DHS and DOH agencies and private Behavioral Health Care providers, develop procedures to expand Medicaid coverage to additional qualified providers.

7. Participate and provide leadership in workgroups with DOH and other state partners in revising Medicaid reimbursement plans and policies.

Indicator: Numbers of individuals receiving SUD services funded by Medicaid and insurance.

Base Line: in FY 2012 17% of individuals were funded by Medicaid or other insurance.

1st year objective: FY 14: 25%

2nd Year Objective: FY 15: 40% By June 30, 2014

Source of DATA: TEDS and Agency reports

Remarks: Utah's governor has not yet decided on the option of expanding Medicaid and will not decide until late September 2013. It is considered highly unlikely that Utah will opt for expansion in 2014, but it is possible that the expansion will be implemented in FY 2015.

State Priority 2: Plan for and implement Wellness and Recovery Oriented Systems of Care principles for persons with mental health and/or substance use disorders.

Goals:

a) Expand the continuum of care to include early interventions and long term support of recovery.

Populations: ALL

Strategies:

1. As SAPTBG funds become available through the expansion of other payment options, Utah will expand ATR type vouchers to provide RSS services
2. Work through the UBHC Data, Financial and Clinical committees to expand the state Substance Abuse and Mental Health Information System (SAMHIS) to allow for tracking of clients outside of the TEDS data system in order to provide recovery support services prior to admission and after discharge from an episode of acute treatment.
3. Continue to work with SAMHSA to modify NOMS and TEDS to reflect and support a Recovery Oriented System of Care.

Indicator: Number of Local Authorities using of Vouchers to provide Recovery Support Services to SUD Priority Populations.

Base Line: 2012: Vouchers used to provide services in three Local Authorities

1st Year Objective: FY 14: Four Local Authorities using Voucher Systems

2nd Year Objective: FY 15: Six Local Authorities using Voucher Systems

Source of DATA: Annual Reports and LA Area Plans

Comments: This is conditional on expansion of funding and retention of SAPT funds for RSS.

Indicator: Use of "Limited Treatment" code in SAMHIS to provide RSS outside of the TEDS episode of acute Care

Base Line: FY 2012: No Local Authorities using.

1st Year Objective: FY 14 Three Local Authorities using code for RSS outside of TEDS episode.

2nd Year Objective: FY 15: Six Local Authorities using code for RSS outside of TEDS episode..

Source of DATA: Annual Reports and LA Area Plans

Goal B: Improve use of data to evaluate treatment and prevention systems and guide improvements and changes.

Populations: All

Strategies:

1. Work through the UBHC Data, Financial and Clinical committees to expand the state Substance Abuse and Mental Health Information System (SAMHIS) to allow for tracking of clients outside of the TEDS data system in order to provide recovery support services prior to admission and after discharge from an episode of acute treatment.
2. Improve the utility of Prevention Data by developing an alternative tracking system that will also provide input to SAMHIS.
3. Develop a Prevention Scorecard to better measure achievement of Prevention goals and objectives.

Indicators: Inclusion of RSS services and pre and post treatment episode of care data in SA and Mental Health Score Cards.

Base Line: See current Scorecards at: **www.dsamh.utah.gov**

1st year: FY 14: Two measures for RSS services on scorecards

2nd year: FY 15: Targets for RSS measures included in Division Directives and used for monitoring reports.

Source of Data: SAMHIS; Audit Reports; Division Directives; Agency Reports.

State Priority 3: Expand children's and adolescent Mental Health and Substance Abuse prevention and treatment services.

Goals A: Reduce life time and 30 day marijuana use for 8th, 10th, and 12th grades through education, awareness and referrals prevention programs.

Strategies:

Indicators: Life Time and 30 day marijuana use data

Base Line: FY 12:

1st Year: FY 14

2nd Year: FY 15

Source of Data. Sharp Survey and Local Authority Reports

Comments:

Goal B: Reduce underage drinking,.

Population: SUD

Strategies:

1. Through Collaboration with partner agencies, develop a comprehensive strategy to:
    a. Reduce availability through compliance.
    b. Delay time of first use and 30 day use.
2. Provide education and awareness to parents of youth within focus population

Indicators:

Base Line: FY 11 www.dsamh.utah.gov/docs/State%20of%20Utah%20Profile%20Report.pdf

1st Year: FY 14 Reduce use by 10 %

2nd Year: FY 15 Maintain reduction

Source of Data: Sharp Survey and BRFS Data

Comments: SHARP survey only done every two years.

State Priority 4: Reduce prescription drug abuse through collaboration with state and local agencies, provide education and awareness to communities.

Populations: All SUD Clients

Goal A: Reduce prescription drug abuse through collaboration with state and local agencies, provide education and awareness to communities

Strategies:

1. Include information and education on Prescription Drug abuse in all Division sponsored and supported conferences and trainings.
2. Participate and provide prevention and treatment expertise in the Department of Health and DEA Prescription Drug Committees.

3. Assist prevention prepared communities in addressing Prescription Drug abuse in their communities as appropriate.
4. Provide information about the benefits of medication assisted therapies to support recovery for opiate and alcohol related admissions.

Indicator: Reduction of Admissions for opiates.

Base Line: FY 12: 21.2%

1st Year: FY 14: 20%

2nd Year: FY 15: 19%

State Priority 5: Build infrastructure of prevention prepared communities through SAPST certification and CTC implementation to prioritize prevention risk factors and focus resources on reducing substance and mental health .

Populations: All SUD and MH

Strategies:

1. Engage citizens to find solutions to substance abuse problems in their communities through research and evidence based programming.
2. Train LSAA and their staff including coalition members and volunteers in SAPST curriculum as needed.
3. Train LSAA and their staff in the CTC model of prevention.
4. Increase the number of trained prevention professionals in the CTC and subsequent coalitions each year

Indicator: Number of CTC

Baseline: 2012: Need a number :

1st Year: 2014: Increase by 25%

2nd Year: 2015: Increase by 45%

Data Source: Area Plans; Monitoring reports

Review of Local Authority reports and Area

Plans

State Priority 6: Provide Services for the following priority populations:

a) Persons who are intravenous drug users (IDU).
b) Women who are pregnant and have a substance use and/or mental disorder**.**
c) Parents with substance use and /or mental disorders who have dependent children
d) Individuals with tuberculosis.
e) Children with serious emotional disturbances (SED) and their families.
f) Adults with Serious Mental Illness (SMI).

Goal B: Provide Services for persons who are intravenous drug users (IDU)

Population: IVDUs

Strategies:

1. Contract with Local Authorities for services as per statute
2. Include Block Grant requirements in Local Authority contracts.

Indicator: Compliance with Contract Requirements

Base Line: FY 2012: Two local authorities had findings, discrepancies or comments regarding services to Priority Population

1st year: FY 14: No more than one local authority has a finding, discrepancy or comment on their annual site visit audit regarding services to priority populations.

2nd year: FY 15: No more than one local authority has a discrepancy or comment on their annual site visit report regarding services to priority populations.

Source of Data: Division Reports.

Goal B: Provide Services for women who are pregnant and have a substance use and/or mental disorder.

Population: SUD; PWWDC: SED

1. Contract with Local Authorities for services as per statute
2. Include Block Grant requirements in Local Authority contracts.

Indicator: Compliance with Contract Requirements

Base Line: FY 2012: Two local authorities had findings, discrepancies or comments regarding services to Priority Population

1st year: FY 14: No more than one local authority has a finding, discrepancy or comment on their annual site visit audit regarding services to priority populations.

2nd year: FY 15: No more than one local authority has a discrepancy or comment on their annual site visit report regarding services to priority populations.

Source of Data: Division Reports.

Goal C: Provide Services for parents with substance use and or mental disorders who have dependent children.

Population: PWWDC; SUD; SED

Strategies:

1. Contract with Local Authorities for services as per statute
2. Include Block Grant requirements in Local Authority contracts.
3. Contract with Local Authorities for services as per statute
4. Include Block Grant requirements in Local Authority contracts.

Indicator: Compliance with Contract Requirements

Base Line: FY 2012: Two local authorities had findings, discrepancies or comments regarding services to Priority Population

1st year: FY 14: No more than one local authority has a finding, discrepancy or comment on their annual site visit audit regarding services to priority populations.

2nd year: FY 15: No more than one local authority has a discrepancy or comment on their annual site visit report regarding services to priority populations.

Source of Data: Division Reports.

Goal D: Provide Services for individuals with tuberculosis

Population: TB

Strategies:

1. Contract with Local Authorities for services as per statute
2. Include Block Grant requirements in Local Authority contracts.

3. Coordinate with Department of Health for coordinated services.

Indicator: Compliance with Contract Requirements

Base Line: FY 2012: Two local authorities had findings, discrepancies or comments regarding services to Priority Populations

1st year: FY 14: No more than one local authority has a finding, discrepancy or comment on their annual site visit audit regarding services to priority populations.

2nd year: FY 15: No more than one local authority has a discrepancy or comment on their annual site visit report regarding services to priority populations.

Source of Data: Division Reports.

Goal E: Provide Services for children with serious emotional disturbances (SED) and their families.

Population: SED

Strategies:

1. Contract with Local Authorities for services as per statute
2. Include Block Grant requirements in Local Authority contracts.

Indicator: Compliance with Contract Requirements

Base Line: FY 2012: Two local authorities had findings, discrepancies or comments regarding services to Priority Population

1st year: FY 14: No more than one local authority has a finding, discrepancy or comment on their annual site visit audit regarding services to priority populations.

2nd year: FY 15: No more than one local authority has a discrepancy or comment on their annual site visit report regarding services to priority populations.

Source of Data: Division Reports.

Goal F: Provide Services for adults with serious mental illness (SMI)

Population: SMI

Strategies:

1. Contract with Local Authorities for services as per statute
2. Include Block Grant requirements in Local Authority contracts.

Indicator: Compliance with Contract Requirements

Base Line: FY 2012: Two local authorities had findings, discrepancies or comments regarding services to Priority Population

1st year: FY 14: No more than one local authority has a finding, discrepancy or comment on their annual site visit audit regarding services to priority populations.

2nd year: FY 15: No more than one local authority has a discrepancy or comment on their annual site visit report regarding services to priority populations.

Source of Data: Division Reports.

State Priority 7: Develop a plan to improve services to the following populations within the state:

a) American Indian;
b) Military personnel and their families;
c) Individuals with mental and or substance abuse disorders who live in rural areas or who are homeless; and
d) Underserved racial, ethnic and LGBTQ populations.

Population: SUD; SMI; SED; Other

Strategies:

1. Provide ongoing education through Generations, U of U June School and Fall Substance Abuse Conferences on cultural competence and special populations.
2. Focus on services to appropriate special populations during site visits to local authorities.
3. Participate in councils representing special populations when BH issues are involved. (DHS Tribal Council; Veteran's Councils; Legislative Committee on Veteran's affairs)
4. Include representatives of special populations in educational planning committees.
5. Review Local Authority Area Plans for emphasis on planning for special populations.

Indicator: Admissions by special populations

Base Line: 2012 TEDS admission data for each population

1st Year: Improve admissions and retention for each of the populations where data is available.

2nd year: Improve admissions and retention by 10% over baseline.

Source of Data: TEDS

Comments: Some populations are not reported by TEDS, nor are there accurate ways to measure or collect the data. An example is LGTBQ admissions are not collected, or asked for. Nor would they be reliable figures, especially in frontier areas of the state. Likewise, Tribal status is not reported and data about veterans status in notoriously inaccurate.

Section IV Block Grant Narrative

C. Coverage M/SUD Services

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

At this time, Utah is still determining whether or not they want to participate in the optional adult Medicaid Expansion. The Governor has indicated he will make a decision sometime in late September and the funding to move forward with this program would need to be approved by the State Legislature, which will convene in late January of 2014.

Utah has received approval from the US Department of Health and Human Services (HHS) to operate a "bifurcated" Health Insurance Exchange (Marketplace). This means that the Utah will have a federally operated Individual Marketplace and a State operated small business Marketplace. The State small business Marketplace, is currently in operation, and is known as Avenue H. Additionally, as a part of the "bifurcated" model, Utah was given authority to maintain regulatory authority of Qualified Health Plans (QHP) on both the federal and state marketplace. This means that the Utah Department of Insurance will be responsible for the certification of QHPs on both the federal and state marketplaces.

During the 2013 Interim Legislative Session, Utah selected its Essential Health Benefit (EHB) benchmark plan. This plan was approved by HHS, despite it not meeting all of the requirements of the Affordable Care Act (ACA). Specifically, the EHB Utah selected does not meet the ACA's standards for ensuring mental health parity for substance use disorder and mental health benefits and it does not meet the standards established for child pediatric vision and dental benefits. The Utah Department of Insurance has acknowledged that the selected plan does not meet mental health parity requirements and have indicated that during the

certification process of QHPs they intend to enforce parity, but have not offered specifics on how they will achieve parity.

Due to the uncertainty that these issues create, many of the answers provided will be conditional and subject to change.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?

The Utah Division of Substance Abuse and Mental Health (DSAMH) intends to use SAPT and MH block grant funding to pay for services not covered by private and/or public insurers. The DSAMH estimates that over 80 percent of the individuals currently being served in the public Substance Use Disorder treatment system and over 95 percent of individuals currently served in the public Mental Health treatment system would qualify for the Medicaid Expansion in the Affordable Care Act (ACA). If Utah chooses to expand access to Medicaid then the DSAMH anticipates shifting block grant funding to Recovery Support Services, early screening and intervention services, and to cover gaps in funding for individuals who are not yet enrolled in Medicaid or other third party insurance. If the state chooses to not expand access to Medicaid, then SAPT and MH block grant funding will be used as they currently are, to provide services to the priority populations and provide the bulk of non Medicaid services in the public system.

The DSAMH continues to work with the Utah Legislature and other state agencies to ensure that the Essential Health Benefits (EHB) plan selected by the state meets the requirements of mental health parity. The EHB selected by the state does not currently meet parity requirements and we are working with the Utah Department of Insurance to determine how to best enforce those requirements during the certification of Qualified Health Plans (QHP).

2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?

The Local Authorities are statutorily required to plan for and provide the Substance Use Disorder (SUD) and Mental Health (MH) Services in Utah. As a result, the Local Authorities are responsible for monitoring whether individuals and families have access to SUD and MH services offered through Qualified Health Plans and Medicaid. The Utah Division of Substance Abuse and Mental Health will work to the Local Authorities to ensure that individuals are enrolled and receiving the appropriate level of care.

3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process?

The Utah Department of Insurance (DOI) is responsible for the certification of all Qualified Health Plans (QHP) in the state of Utah. The deadline for QHPs to submit applications to the DOI was the end of June, and the review process of these applications has begun. The Division of Substance Abuse and Mental Health (DSAMH) has notified the DOI that the Essential Health Benefits plan selected by the state does not meet mental health parity requirements. The DOI is working on establishing a process for enforcing parity among QHPs in Utah.

4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?

The Utah Division of Substance Abuse and Mental Health (DSAMH) anticipates receiving complaints from the Local Authorities and clients on violations of MHPAEA. The DSAMH does not have authority to directly address complaints, so it will be necessary for us to partner with the Department of Insurance (DOI) on addressing these issues. The DSAMH would like to establish a process with the DOI to address these complaints, but at this point a formal process has not yet been established.

5. What specific changes will the state make in what is bought given the coverage offered in the state's EHB package?

Behavioral health services are provided through cost based reimbursement contracts that exist between the Utah Division of Substance Abuse and Mental Health (DSAMH) and the Local Authorities. The DSAMH does not currently purchase any specific services. The DSAMH does require the local authorities provide specific

services, which are outlined in Utah Statute 62A-15 **(**http://le.utah.gov/UtahCode/section.jsp?code=62A-15**)** and 17-43 **(**http://le.utah.gov/UtahCode/section.jsp?code=17-43**).** These services are further expanded upon in Administrative Rule **(**http://ww.rules.utah.gov/publicat/code/r523/r523.htm**).** These require that the Local Authorities provide 10 mandated mental health services and a "continuum of services" for treatment of Substance Use Disorders (SUD). As other funding sources such as Medicaid and Qualified Health Plans (QHP) cover the basic required services, the DSAMH will direct that the Local Authorities shift state and federal funds portions of the continuum of services not covered by insurance. This will be done through additions to the DSAMH directives and monitored through the Local Authorities success in implementing those directives through their annual Area Plans.

D. Affordable Insurance Marketplace

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?
Requested section, state is not addressing.

2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?
Requested section, state is not addressing.

3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing third party Medicaid, the CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?
Requested section, state is not addressing.

4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?

Currently all of the providers that are contracted with the DSAMH are eligible for Medicaid reimbursement and are working to expand their participation in other insurance plans. The DSAMH is also working on partnering with the Utah Department of Insurance to provide education to providers on mental health parity and working with third party payers. The DSAMH will continue to stay involved in conversations with the advocates, the Department of Insurance, and the legislature with regards to QHPs network adequacy standards and work to ensure that providers who contract with the DSAMH are also contracting with willing QHPs.

5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.

Seventeen percent of SUD clients currently receiving treatment are covered by Medicaid. Ninety percent of the remaining population is uninsured (approximately 13,000 individuals in FY 12). Most of the clients served in the Mental Health Centers are covered by Medicaid, but it is estimated that at least 15 percent of current clients are currently uninsured.

6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.

This depends totally on whether or not Utah adopts a Medicaid expansion (ME). If Utah moves forward with ME, it is anticipated that by 2015, the number of individuals not insured will mirror the Massachusetts experience. Initially they found that 20-30% of individuals seeking SUD/MH services were uninsured at admission. Given that figure we anticipate that approximately 4500 SUD clients and 8000 MH clients will be uninsured at admission. We anticipate that the numbers of uninsured will drop dramatically from close to 100% of SUD clients and non SPMI MH clients in FY 13 through FY 14 to reach the percentage of clients

7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2012 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.

Currently 100% of the providers that are contracted with the Division are eligible for Medicaid reimbursement and are working to expand their participation in other insurance plans.
It is not an estimate.

8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

All of the providers that the DSAMH works with are eligible for Medicaid reimbursement. QHPs are still in the process of certifying with the Utah Department of Insurance and at this point it is uncertain how many of them have chosen to include providers in the public health system in their networks.

E. Program Integrity

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?

2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?

3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:

a. Budget review;

b. Claims/payment adjudication;

c. Expenditure report analysis;

d. Compliance reviews;

e. Encounter/utilization/performance analysis; and

f. Audits.

At this time, Utah is still determining whether or not they want to participate in the optional adult Medicaid Expansion. The Governor has indicated he will make a decision sometime in late September and the funding to move forward with this program would need to be approved by the State Legislature, which will convene in late January of 2014.

Utah has received approval from the US Department of Health and Human Services (HHS) to operate a "bifurcated" Health Insurance Exchange (Marketplace). This means that the Utah will have a federally operated Individual Marketplace and a State operated small business Marketplace. The State small business Marketplace, is currently in operation, and is known as Avenue H. Additionally, as a part of the "bifurcated" model, Utah was given authority to maintain regulatory authority of Qualified Health Plans (QHP) on both the federal and state marketplace. This means that the Utah Department of Insurance will be responsible for the certification of QHPs on both the federal and state marketplaces.

During the 2013 Interim Legislative Session, Utah selected its Essential Health Benefit (EHB) benchmark plan. This plan was approved by HHS, despite it not meeting all of the requirements of the Affordable Care Act

(ACA). Specifically, the EHB Utah selected does not meet the ACA's standards for ensuring mental health parity for substance use disorder and mental health benefits and it does not meet the standards established for child pediatric vision and dental benefits. The Utah Department of Insurance has acknowledged that the selected plan does not meet mental health parity requirements and have indicated that during the certification process of QHPs they intend to enforce parity, but have not offered specifics on how they will achieve parity.

Due to the uncertainty that these issues create, many of the answers provided will be conditional and subject to change.

1. Does the state have a program integrity plan regarding the SABG and MHBG?

Yes

2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?

Yes

3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:

a. Budget review: Yes

b. Claims/payment adjudication: Yes we deal with complaints

c. Expenditure report analysis: Yes

d. Compliance reviews: Yes

e. Encounter/utilization/performance analysis: Yes

f. Audits: Yes

4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?

The Utah Division of Substance Abuse and Mental Health (DSAMH) conduct yearly audit visits of each local authority. These audits allow the DSAMH to review billing documents, compare service costs between similar providers (rural and urban), and compare outcome data, per client costs and client satisfaction surveys and complaints. Additionally, these annual audits allow the DSAMH to assess each local authority's compliance with federal and state requirements, prescribed billing practices and accounting procedures, clinical practice guidelines and procedures, and with requirements for clinical documentation. Finally, the annual audit allows the DSAMH to interview local authority clients, review Client Satisfaction Surveys and evaluate outcome measures to assess the effectiveness of the program.

5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

There are numerous ways the Utah Division of Substance Abuse and Mental Health (DSAMH) assists providers in adopting best practices that promote compliance with program requirements. During yearly audit visits to the each local authority the DSAMH conducts compliance checks and provides technical assistance on improving procedures and practices. Additionally, the DSAMH sponsors a number of statewide training conferences the provide regular training opportunities to providers including—the Generations Conference, the Fall Substance Abuse Conference, and het Utah Valley Addictions Conference. Additionally, the DSAMH holds semi annual meetings of the Utah Behavioral Health Care Committee that includes meetings with agency directors, clinical directors, finance directors, and data/information systems directors. Finally, the DSAMH conducts an annual training of our Division Directives, which allows the DSAMH to highlight any changes to existing requirements or new requirements the local authorities are expected to meet during the upcoming year. Once the Division Directive is presented to the local authorities, they submit an annual Area Plan outlining how each local authority plans on meeting DSAMH requirements and the plans are reviewed and approved by DSAMH leadership.

6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

This is currently monitored through the audit process explained above. Audit teams consist of administrative, financial and clinical staff from the Utah Division of Substance Abuse and Mental Health (DSAMH). Additionally, as stated earlier, contracts with the Local Authorities are cost reimbursement

contracts, and services for clients with Medicaid, Medicare, and other insurance are billed separately to those agencies.

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

F. Use of Evidence in Purchasing Decisions

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

SAMHSA is requesting that states respond to the following questions:

1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?

Yes, the Utah Division of Substance Abuse and Mental Health (DSAMH) employees a Program Administrator for each of the following areas—Substance Use Disorder (SUD) treatment services, Adult Mental Health Services, Children's Mental Health Services, Access to Recovery Services, and SUD Prevention services. Each Program Administrator is responsible for researching evidence based practices and providing training to providers; as well as supporting and monitoring the implementation of statewide evidence based practices. Additionally, each Program Administrator works to expand the use of EBPs that the Local Authorities choose to implement in their own areas based on their assessment of need and effectiveness of the EBP to meet those needs.

2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?

The Utah Division of Substance Abuse and Mental Health (DSAMH) is primarily a pass through agency that contracts with Local Authorities on a cost reimbursement basis. Planning for providing direct services is the responsibility of the Local Authority. Although the DSAMH does use information regarding evidence-based or promising practices in our policy decisions and in setting requirements for the Local Authorities.

a) What information did you use?

The Utah Division of Substance Abuse and Mental Health (DSAMH) uses multiple sources to inform our policy decisions on evidence based practices. These include, but are not limited to the following:

- Documents published and distributed by SAMHSA;
- SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP);
- Prevention's Planning Process;
- Practices shared by Local Substance Abuse and Mental Health Authorities through the Utah Behavioral HealthCare Clinical committee;
- Research from other sources (AATOD, CESAR Fax, NIDA, NIAA, NASADAD, NASMHPD, etc); and
- Practice Guidelines developed collaboratively with the Local Authorities.

b) What information was most useful?

Each of the above sources has strengths and weakness and all are useful.

3) How have you used information regarding evidence-based practices?

a) Educating State Medicaid agencies and other purchasers regarding this information?

b) Making decisions about what you buy with funds that are under your control?

As established by Utah state statute, the Division of Substance Abuse and Mental Health (DSAMH) is not authorized to purchase direct services. As a result information on evidence-based practices is not used by the DSAMH in purchasing decisions. However, we do disseminate information on evidence-based practices to educate providers, consumers, partners, and administrators and develop specific policies in our contracts that local authorities must adhere to.

G. Quality

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use-Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposures to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc -TEDS	Clients w/SMI or SED who are employed, or in school

1) What additional measures will your state focus on in developing your State BG Plan (up to three)?

See scorecards below.

2) Please provide information on any additional measures identified outside of the core measures and state barometer.

See score cards below.

3) What are your states' specific priority areas to address the issues identified by the data?

Utah's priority in Substance Use Disorder (SUD) treatment and prevention is to expand the continuum of care to include early identification and intervention, increasing the availability of recovery support services, and relapse prevention services to support long term recovery. Utah's Mental Health priorities are to expand services past the traditional Medicaid population, as well as to improve the range of employment and recovery services available. An additional priority for both SUD and Mental Health Services is to reduce the impact of stigma on the ability of individuals to seek out and utilize treatment services and to improve the availability of services to support those individuals in their recovery.

4) What are the milestones and plans for addressing each of your priority areas?

The Utah Division of Substance Abuse and Mental Health (DSAMH) anticipate that achieving these priorities will take three to five years. There will be many challenges in achieving these priorities including the nature of the behavioral health care system in Utah, variation in the Local Authorities priorities as defined by County Governments, and the nature of the DSAMH priorities. These priorities are focused more on cultural changes rather than practice changes, making it difficult to establish a statewide schedule. Additionally, reducing stigma requires changing attitudes of employers, landlords, administrators, government officials and the public; as well as changing the attitudes of the current behavioral health workforce.

FY 2012 Mental Health Scorecard for Adults

September 28, 2012

Local Authority	Number of Clients Served		Estimate of Need at 300% of Poverty*					# SPMI Served		Unfunded		Supported Housing/In Home Skills		Jail Services		Employment					
			# In Need of Treatment	% In Need of Treatment	% of Need Served	# In Need of Treatment SPMI	% SPMI Need Served									Supported Employment		# Employed		% Employed	
	FY2011	FY2012						FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012
Rural Counties																					
Bear River	1,972	1,972	6,760	5.9%	29.2%	1,928	86.9%	1,660	1,675	33	28	38	34	149	229	18	14	342	329	54.6%	61.0%
Central	702	760	3,178	6.1%	23.9%	961	58.8%	534	565	136	143	0	0	0	3	6	6	135	146	58.4%	58.4%
Four Corners	1,050	914	1,836	6.1%	49.8%	576	106.3%	652	612	619	69	0	2	14	0	0	0	336	194	76.4%	71.1%
Northeastern	885	955	2,349	6.6%	40.7%	740	45.8%	353	339	346	331	20	19	3	9	0	0	296	352	63.9%	70.5%
San Juan	385	415	955	9.6%	43.5%	322	29.8%	94	96	119	117	0	0	0	0	1	1	150	163	78.1%	81.1%
Southwest	1,290	1,367	9,386	6.4%	14.6%	2,827	31.0%	821	875	376	366	8	20	6	1	8	5	250	288	48.8%	52.4%
Summit Co.	581	536	1,309	4.8%	45.7%	379	47.2%	176	179	53	45	0	0	0	4	14	6	332	337	86.2%	84.9%
Tooele Co.	1,269	1,215	2,196	5.8%	55.3%	657	144.3%	892	948	111	68	1	0	14	3	8	6	375	353	77.0%	77.8%
Wasatch Co. - Heber	325	285	742	4.6%	38.4%	217	21.2%	74	46	206	159	0	0	6	3	0	0	139	113	65.3%	73.9%
Total	8,430	7,045	28,711	6.1%	24.5%	8,607	61.8%	5,236	5,317	1,990	1,321	67	75	192	249	55	38	2,347	2,264	66.4%	68.6%
Urban Counties																					
Davis	2,290	2,698	8,269	4.0%	32.6%	2,448	73.1%	1,738	1,790	406	297	75	81	224	786	52	49	448	569	48.5%	56.4%
Salt Lake Co.	10,936	10,046	38,060	5.1%	26.4%	11,040	67.8%	7,538	7,483	1,661	377	425	218	67	4	224	200	1,908	1,752	69.9%	65.9%
Utah Co. - Wasatch MH	4,145	4,455	21,652	6.3%	20.6%	6,089	39.5%	2,867	2,403	716	706	170	210	21	7	0	10	655	703	49.3%	51.8%
Weber	4,308	4,165	9,463	5.5%	44.0%	2,805	45.6%	1,610	1,280	1,592	1,552	32	37	1,258	1,129	0	5	528	402	42.7%	52.8%
Total	21,407	21,764	77,444	5.3%	28.1%	22,382	57.1%	13,963	12,772	4,305	2,883	695	542	1,545	1,870	276	261	3,510	3,387	57.1%	59.3%
State	29,489	29,205	105,369	5.4%	27.7%	30,813	57.9%	18,943	17,851	6,220	4,167	754	612	1,720	2,092	323	296	5,791	5,615	60.4%	62.9%

- Client totals are unduplicated across areas; i.e., State is unduplicated across the state, Rural is unduplicated across the rural centers, etc.
- Clients can receive multiple services and where applicable are duplicated.
- Supported employment includes # of clients with a supported employment status anytime during the fiscal year.
- Supported Housing/In Home Skills includes # of clients that received that service anytime during the fiscal year (DSAMH service code #174).
- Jail Services and In-Home Services includes # of clients who received services with a location code of Jail or In Home.
- Employment includes # of clients who were employed or did not stay unemployed during the fiscal year.
- % Employed includes # of clients employed (full time, part time, or supported employment) divided by the number of clients in the workforce. Workforce includes clients who are employed (full time, part time or supported employment) and/or unemployed but seeking work.

*Holzer, C.E., & Nguyen, H. T. (2008). Synthetic Estimates of Mental Health Needs for Utah (based on the Collaborative Psychiatric Epidemiological Surveys and the U.S. Census 2009 Population Estimates), from www.charles.holzer.com **Note:** These estimates are based on the Collaborative Psychiatric Epidemiological Surveys (CPES) conducted in 2001 to 2003 and the U.S. Census updated to 2009, using the MHM3 broad definition and the MHM1 definition at 300% of poverty. The MHM3 definition requires a current or chronic disorder and a disability duration of at least 30 days, and is comparable to Seriously Mentally Disturbed (SMD). For children and adolescents, the estimates use poverty levels to assign rates of Serious Emotional Disturbance (SED). The MHM1 definition includes Severe and Persistent Mental Illness.

Notes for page 2:

Red: Minimun requirements not met.
Orange: Median number of days/hours or utilization percentages are below 75% or above 300% of the rural or urban median or utilization totals.

Utilization: Percent of all clients receiving services. Total Outpatient number of clients served is an unduplicated count by provider of any client receiving an outpatient service.
Median Length of Stay: Median length of time for all clients who received that service. Median is the middle value in a list of numbers.
Average Length of Stay: Average length of time for all clients who received that service. Average or mean is the total number of time for that service divided by the number of clients receiving that service.
Inpatient includes MHE service code 170
Residential includes MHE service codes 171 and 173
Medication Management includes MHE service codes 61
Psycosocial Rehabilitation includes MHE service codes 70, 80, 100, 120, and 160
Target Case Management includes MHE service code 130
Respite includes MHE service code 150
Assessment includes MHE service code 22 Diagnosis and Assessment
Testing is not shown on the scorecard but is included in Total Outpatient
Treatment Therapy includes MHE service codes 30 Individual Therapy, 31 Electroconvulsive Therapy, 35 Individual Behavior Management, 40 Family Therapy, and 50 Group Therapy
Total Outpatient includes all MHE service codes except those reported on the same day as a bed day (170 Inpatient, 171 Residental, and 173 Residental Support)
Emergency includes all service codes with emergency indicator set to "yes."
Peer Support services includes MHE service codes 130 Peer Support.
State Hospital data used to calculate utilization, median and average number of days in the state hospital during the fiscal year only.

FY 2012 Mental Health Scorecard for Children and Youth (age 17 and younger)

September 28, 2012

Local Authority	Number of Clients Served		Estimate of Need at 300% of Poverty*			# SED Served		Unfunded		Youth Enrolled in School		Youth Employed		Justice Services	
	FY2011	FY2012	# in Need of Treatment	% in Need of Treatment	% of Need Served	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012
Rural Counties															
Bear River	1,162	1,120	2,731	6.14%	41.0%	777	795	148	167	988	974	19	14	4	20
Central	417	488	1,398	6.82%	34.8%	316	370	36	45	377	446	0	1	0	0
Four Corners	494	437	567	4.93%	78.5%	343	308	378	19	403	356	18	8	1	0
Northeastern	448	561	892	5.06%	61.8%	144	142	116	121	339	433	8	4	0	6
San Juan	163	153	338	6.82%	45.5%	31	22	34	37	155	149	0	0	0	0
Southwest	1,452	1,558	3,602	6.86%	43.3%	937	1,026	318	190	1,213	1,334	4	1	3	8
Summit Co.	230	217	458	4.42%	47.8%	60	73	36	21	209	203	12	23	0	6
Tooele Co.	472	526	968	4.56%	54.2%	327	386	43	44	446	476	7	9	0	0
Wasatch Co. - Heber	123	136	321	3.92%	42.1%	22	21	78	62	93	116	6	9	0	0
Total	4,930	5,183	11,261	5.30%	45.8%	2,940	3,105	1,181	883	4,204	4,474	71	69	8	36
Urban Counties															
Davis	1,290	1,446	3,884	3.75%	38.3%	1,238	1,329	124	48	1,155	1,313	2	2	0	6
Salt Lake Co.	5,206	4,702	13,422	4.42%	35.0%	4,346	3,793	528	209	4,478	4,082	23	22	0	6
Utah Co. - Wasatch MH	2,886	2,856	9,348	5.07%	30.6%	2,189	2,198	152	90	2,513	2,492	50	41	16	6
Weber	1,550	1,478	3,461	4.72%	42.7%	1,112	1,087	130	81	1,272	1,282	28	17	8	18
Total	10,817	10,380	30,213	4.62%	34.4%	8,786	8,324	922	419	9,328	9,086	102	81	23	32
State	15,598	15,406	41,373	4.70%	37.2%	11,619	11,315	2,084	1,094	13,396	13,425	173	150	31	68

Client totals are unduplicated across areas; i.e., State is unduplicated across the state, Rural is unduplicated across the rural centers, etc.
Clients can receive multiple services and where applicable are duplicated.

Youth Enrolled in Education includes # of clients that were enrolled in education anytime during the fiscal year.
Youth Employed includes # of clients who were employed or did not stay unemployed during the fiscal year.
Justice Services includes # of clients with services using a location code of Jail.

*Holzer, C.E., & Nguyen, H. T. (2008). Synthetic Estimates of Mental Health Needs for Utah (based on the Collaborative Psychiatric Epidemiological Surveys and the U.S. Census 2009 Population Estimate), from www.charles.holzer.com Note: These estimates are based laborative Psychiatric Epidemiological Surveys (CPES) conducted in 2001 to 2003 and the U.S. Census updated to 2009, using the MHM3 broad definition and the MHM1 definition at 300% of poverty. The MHM3 definition requires a current or chronic disorder and a dis of at least 30 days, and is comparable to Seriously Mentally Disturbed (SMD). For children and adolescents, the estimates use poverty levels to assign rates of Serious Emotional Disturbance (SED). The MHM1 definition include Severe and Persistent Mental Illness.

Notes for page 2:

Red: Minimun requirements not met.
Orange: Median number of days/hours or utilization percentages are below 75% or above 300% of the rural or urban median or utilization totals.

Utilization: Percent of all clients receiving services. Total Outpatient number of clients served is an unduplicated count by provider of any client who receives an outpatient service.
Median Length of Stay: Median length of time for all clients who received that service. Median is the middle value in a list of numbers.
Average Length of Stay: Average length of time for all clients who received that service. Average or mean is the total number of time for that service divided by the number of clients receiving that service.
Inpatient includes MHE service code 170
Residential includes MHE service codes 171 and 173
Medication Management includes MHE service codes 61
Psycosocial Rehabilitation includes MHE service codes 70, 80, 100, 120, and 160
Target Case Management includes MHE service code 130
Respite includes MHE service code 150
Assessment includes MHE service code 22 Diagnosis and Assessment
Testing is not shown on the scorecard but is included in Total Outpatient
Treatment Therapy includes MHE service codes 30 Individual Therapy, 31 Electroconvulsive Therapy, 35 Individual Behavior Management, 40 Family Therapy, and 50 Group Therapy
Outpatient includes all MHE service codes except 170 Inpatient, 171 Residental, 173 Residental Support, and 174 Housing/In Home Skills
Emergency includes all services codes with emergency indicator set to "yes."
Peer Support Services includes MHE service code 130 Peer Support.
In-Home and School-Based Services are based on service location code.
State Hospital data used to calculate utilization, median and average days of service during the fiscal year only.

FY 2012 Mental Health Scorecard for Children and Youth (age 17 and younger)

September 28, 2012

Local Authority	Number of Clients Served		Estimate of Need at 300% of Poverty*			# SED Served		Unfunded		Youth Enrolled in School		Youth Employed		Justice Services	
	FY2011	FY2012	# In Need of Treatment	% In Need of Treatment	% of Need Served	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012
Rural Counties															
Bear River	1,152	1,120	2,731	6.14%	41.0%	777	795	148	167	888	974	19	14	4	20
Central	417	486	1,398	6.82%	34.8%	316	370	36	45	377	448	0	1	0	0
Four Corners	484	437	567	4.93%	78.5%	343	308	378	19	403	356	18	8	1	0
Northeastern	448	551	892	6.05%	61.8%	144	142	118	121	338	433	6	4	0	5
San Juan	163	163	338	6.82%	45.5%	31	22	34	37	155	149	0	0	0	0
Southwest	1,462	1,558	3,802	6.85%	43.3%	937	1,026	319	190	1,213	1,334	4	1	3	8
Summit Co.	230	217	468	4.42%	47.6%	60	73	36	21	209	203	12	23	0	5
Tooele Co.	472	626	968	4.68%	54.2%	327	386	43	44	445	476	7	9	0	0
Wasatch Co. - Heber	123	136	321	3.92%	42.1%	22	21	78	62	93	116	5	9	0	0
Total	4,930	5,163	11,261	6.30%	45.8%	2,940	3,106	1,181	683	4,204	4,474	71	69	8	38
Urban Counties															
Davis	1,290	1,446	3,984	3.75%	36.3%	1,238	1,329	124	48	1,155	1,313	2	2	0	5
Salt Lake Co.	5,206	4,702	13,422	4.42%	35.0%	4,348	3,783	528	209	4,478	4,082	23	22	0	5
Utah Co. - Wasatch MH	2,885	2,856	9,348	6.07%	30.6%	2,189	2,198	162	90	2,513	2,492	50	41	15	5
Weber	1,550	1,479	3,481	4.72%	42.7%	1,112	1,087	130	81	1,272	1,262	28	17	8	18
Total	10,817	10,380	30,213	4.62%	34.4%	8,795	8,324	922	419	9,328	9,066	102	81	23	32
State	15,598	15,406	41,373	4.70%	37.2%	11,619	11,315	2,084	1,084	13,396	13,425	173	150	31	68

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FY2012 Utah Substance Abuse Treatment Outcomes Measures Scorecard for all clients

8/27/2012

Process Measures

	Admissions (Initial and Transfer)		Number of Clients Served		Percent of Admissions in Outpatient/IOP/ Residential/Detox		Number of Final Discharges, excluding Detox		Median Days in Treatment		Percent of clients in retained in treatment 60 or more days		Percent Completing Treatment Episode Successfully	
LSAA	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012
Bear River	905	1,101	1,377	1,481	84/16/1/0	85/14/1/0	904	1,026	105	79	61.8%	57.5%	46.8%	45.4%
Central Utah	211	243	338	385	94/6/0/0	91/8/1/0	160	212	104.5	127	71.9%	70.8%	25.0%	37.7%
Davis County	916	847	1,001	931	75/22/3/0	71/28/0/0	858	874	115	158	67.6%	78.6%	40.8%	42.0%
Four Corners	575	572	634	584	74/25/1/0	74/24/2/0	429	314	55	47	49.0%	47.5%	27.3%	34.7%
Northeastern	398	383	604	559	98/2/0/0	100/0/0/0	230	123	66	114	54.3%	69.9%	35.2%	42.3%
Salt Lake County	9,150	9,280	6,759	7,193	24/22/8/47	29/19/8/44	3,537	3,538	123	115	76.7%	75.4%	49.3%	45.3%
San Juan County	98	108	146	188	97/1/2/0	97/1/2/0	56	99	138	119	78.6%	71.7%	32.1%	33.3%
Southwest Center	549	565	616	570	46/33/20/0	52/28/20/0	512	470	148	167.5	85.4%	85.3%	59.4%	58.1%
Summit County	130	102	240	163	75/23/1/1	79/21/0/0	177	93	126	128	73.4%	80.6%	63.8%	57.0%
Tooele County	298	214	461	326	79/20/1/0	80/20/0/0	312	187	139	143	74.7%	75.9%	51.6%	50.3%
Utah County	1,066	1,481	1,103	1,324	38/36/21/5	29/26/39/6	724	973	117.5	69	67.5%	53.1%	40.3%	53.1%
Wasatch County - Heber Valley	75	114	98	115	71/21/8/0	83/14/3/0	76	85	114.5	114	78.0%	78.8%	32.9%	38.8%
Weber Human Services	966	1,127	1,287	1,398	76/17/7/0	79/15/6/0	858	951	143	138	78.6%	78.5%	46.9%	51.0%
Statewide Contracts	1,247	1,147	2,228	2,333										
State Average/Total	16,583	17,264	16,454	17,026	43/20/11/26	45/19/12/24	8,833	8,745	120	114	72.1%	70.8%	46.1%	46.6%
State Urban Average/Total	12,098	12,735	10,101	10,780	33/22/8/36	36/20/11/33	5,977	6,136	125	116	74.5%	72.7%	46.7%	47.0%
State Rural Average/Total	3,238	3,382	4,508	4,360	78/18/4/0	79/17/4/0	2,856	2,609	110	109	67.0%	66.3%	44.8%	45.7%
National Average														

Outcome Measures

	Increased Alcohol Abstinence - Percent increase in those reporting alcohol abstinence from admission to discharge		Increased Drug Abstinence - Percent increase in those reporting other drug abstinence from admission to discharge		Increase in Stable Housing - Percent increase in non-homeless clients admission to discharge		Increased Employment - Percent increase in those employed full/part time or student from admit to discharge		Decreased Criminal Justice Involvement - Percent decrease in number of clients arrested prior to admission to prior to discharge	
LSAA	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012
Bear River	170.8%	196.3%	126.5%	148.5%	**	-0.4%	17.1%	7.4%	93.9%	96.6%
Central Utah	30.3%	28.3%	92.9%	53.8%	0.6%	-0.5%	16.9%	7.2%	46.8%	73.0%
Davis County	17.9%	19.0%	96.3%	109.0%	-0.4%	0.0%	10.4%	14.8%	71.9%	73.0%
Four Corners	33.4%	26.3%	46.2%	26.6%	-0.2%	0.3%	7.3%	5.1%	63.8%	22.8%
Northeastern	33.1%	63.4%	45.8%	62.7%	0.0%	*	14.9%	31.2%	53.0%	75.1%
Salt Lake County	20.6%	23.9%	69.3%	59.8%	4.0%	4.1%	30.4%	23.1%	70.8%	59.5%
San Juan County	60.1%	65.5%	11.4%	13.8%	*	*	17.6%	6.6%	25.2%	61.1%
Southwest Center	32.1%	37.6%	169.3%	175.4%	-1.7%	-3.8%	40.7%	39.7%	58.5%	48.7%
Summit County	201.5%	222.3%	60.9%	57.8%	0.5%	1.1%	8.1%	10.8%	67.7%	47.0%
Tooele County	131.5%	52.0%	111.5%	87.8%	0.8%	-1.8%	25.8%	26.1%	67.7%	46.9%
Utah County	53.6%	65.5%	219.0%	520.7%	0.2%	0.8%	40.4%	38.6%	63.2%	46.5%
Wasatch County - Heber Valley	142.4%	196.1%	151.8%	508.5%	*	1.2%	24.5%	38.1%	72.2%	81.0%
Weber Human Services	110.5%	102.8%	185.9%	261.5%	0.9%	0.5%	28.7%	44.9%	81.1%	82.1%
Statewide Contracts										
State Average/Total	48.2%	47.5%	94.2%	102.0%	1.8%	1.5%	24.5%	22.8%	70.8%	64.1%
State Urban Average/Total	37.6%	36.7%	93.8%	102.3%	2.4%	2.6%	27.8%	27.2%	72.3%	65.4%
State Rural Average/Total	78.2%	83.1%	95.0%	101.9%	-0.1%	-0.8%	19.2%	15.2%	66.8%	59.7%
National Average	36.7%	36.7%	44.9%	44.9%	2.7%	2.7%	12.8%	12.8%	50.4%	50.4%

Note: Outcomes exclude detox discharges

Salt Lake, Davis, Weber (Wagon is included in Weber County), and Utah Counties are reported as Urban. All other counties are reported as rural.

Green = 95% or greater of the National Average.
Yellow = Greater than or equal to 75% to less than 95% of the National Average.
Red = Less than 75% of the National Average.

* No one homeless at admission so no opportunity for change.
** No one reported at discharge.
n/a = no clients reported/not applicable to incarcerated population.
Decreased Use and Completing Modality Successfully are not national measures and are not scored.

State Total for Clients Served is an unduplicated client count across all modalities and is not a sum of the clients served for the providers listed.
Final Discharges are reported by treatment episode.

Admissions are the number of duplicated admissions to a treatment modality that occurred within the fiscal year. Clients served are an unduplicated count of clients served during the fiscal year. Due to a change in reporting procedure, The numbers on this chart may not be the same as reported in previous years.

Calculations for SA Outcomes:

All outcomes are percent increase or decrease. Specific percentages are calculated as follows using FY final discharges, excluding detox-only clients. Percents at admission and discharge are calculated by dividing the number of clients reporting the outcome divided by the total number of discharged clients with valid, non-missing, data for that measure:

Abstinence (Percent Increase):
(Percent abstinent at discharge *minus* percent abstinent at admission) ***divided by*** percent abstinent at admission

Stable Housing (Percent Increase):
(Percent not homeless at discharge *minus* percent not homeless at admission) ***divided by*** percent not homeless at admission.

Employment/School (Percent Increase):
(Percent employed/student at discharge *minus* percent employed/student at admission) ***divided by*** percent employed/student at admission.

Criminal Justice (Percent Decrease):
(Percent arrested at 30-days prior to admission *minus* percent arrested 30-days prior to discharge) ***divided by*** percent arrested 30-days prior to admission.

Length of Stay:
Median length of stay calculated from admission date to date of last contact for those discharged in the fiscal year

Adult Consumer Satisfaction Survey 2012 combined MH and SA Clients — 9/26/2012 — Scoreboard

Agency	Number Served FY2011		Number of Forms Returned 2011	2012	Percent of Clients Sampled		General Satisfaction		Good Service Access		Quality & Appropriateness of Services		Participation in Treatment Planning		Positive Service Outcomes		Social Connectiveness		Improved Functioning		Wellness	
Bear River Health Dept.	1,248	↑	139	151	12.1%	→	72	↓	76	→	89	↓	68	→	78	→	84	→	81	→	86
Bear River Mental Health	1,972	↑	498	562	28.5%	→	90	→	88	↓	84	↓	70	↓	56	↓	67	↓	64	→	78
Central Utah	901	↑	172	85	9.4%		*		*		*		*		*		*		*		*
Davis Behavioral	3,006	↑	430	437	14.5%	↑	89	↓	78	→	83	↑	82	→	64	↑	71	↑	71	→	81
Four Corners	1,308	↑	246	387	29.6%	↓	81	↓	83	→	80	→	75	↓	62	↓	69	→	71	↓	78
Northeastern	1,280	↑	344	374	29.2%	→	80	↓	78	→	74	→	70	↓	61	→	71	→	71	→	78
Salt Lake Co.	15,990	↑	4,414	3,109	19.4%	→	83	→	76	→	76	→	72	→	63	→	76	→	76	→	77
San Juan	462	↑	50	66	13.7%	→	89	→	89	↓	88	→	87	↓	70	→	73	→	72	→	88
Southwest	1,770	↑	248	238	13.4%	→	89	→	85	↓	86	→	81	↓	68	↓	68	↓	68	→	82
Summit Co. - Valley Mental Health	751	↑	185	153	20.4%	→	90	↓	80	↓	78	↓	70	↓	64	→	81	↓	69	→	79
Tooele Co. - Valley Mental Health	1,540	↑	334	187	12.1%	→	84	→	78	→	83	→	75	↓	67	→	78	→	74	→	74
U of U	358	↑	31	40	11.2%	→	100	→	90	→	95	→	83	→	78	→	98	→	90	→	90
Utah Co. - Wasatch Mental Health	4,145	↑	534	483	11.7%	↑	90	→	81	→	81	→	76	→	60	→	66	→	67	↑	76
Utah County Substance Abuse	998	↑	412	478	47.9%	→	83	↓	80	↓	80	↓	70	→	78	→	84	→	85	→	85
Wasatch Co. - Heber Valley Counseling	353	↑	137	118	33.4%	→	93	→	92	↓	89	↓	80	↓	65	→	72	↓	70	→	78
Weber	4,753	↑	728	731	15.4%	→	87	→	83	→	83	→	75	→	60	↑	73	→	70	↑	79
State	39,647	↑	8,900	7,599	19.2%		85		76		80		75		64		72		71		76
National (2011)							88		85		88		80		71		70		70		

Adult Consumer Satisfaction Survey 2012 MH Clients

Agency	Number Served FY2011		Number of Forms Returned 2011	2012	Percent of Clients Sampled		General Satisfaction		Good Service Access		Quality & Appropriateness of Services		Participation in Treatment Planning		Positive Service Outcomes		Social Connectiveness		Improved Functioning		Wellness	
Bear River Mental Health	1,972		498	562	28.5%	→	90	→	88	↓	84	↓	70	↓	56	→	67	↓	64	→	78
Central Utah	702		126	65	9.3%		*		*		*		*		*		*		*		*
Davis Behavioral	2,290		244	269	11.7%	→	89	↓	76	→	84	→	81	↓	50	→	61	→	63	↑	74
Four Corners	1,049		167	259	24.7%	↓	83	↓	84	→	79	→	77	→	58	→	65	↑	89	↓	77
Northeastern	887		200	230	25.9%	→	83	→	81	→	74	→	70	→	58	↓	66	→	67	↑	74
Salt Lake Co	10,957		2,912	1,882	17.0%	→	84	→	74	→	75	→	73	→	54	→	62	→	63	→	68
San Juan	385		37	53	13.8%	→	91	→	91	↓	88	→	86	→	71	↑	73	→	71	↑	88
Southwest	1,290		150	162	12.6%	→	91	→	90	↓	86	→	80	→	54	→	57	→	60	→	78
Summit Co. - Valley Mental Health	581		105	91	15.7%	→	93	→	87	↓	79	→	85	↓	64	→	67	↓	66	→	81
Tooele Co. - Valley Mental Health	1,269		154	105	8.3%		*		*		*		*		*		*		*		*
Utah Co. - Wasatch Mental Health	4,145		534	483	11.7%	↑	90	→	81	→	81	→	76	→	60	→	66	→	67	↑	76
Wasatch Co. - Heber Valley Counseling	326		108	89	27.3%	→	92	→	91	↓	82	↓	78	→	58	→	64	→	61	→	73
Weber	4,308		491	478	11.1%	→	87	→	83	→	83	→	75	↓	53	→	65	→	69	↑	74
State	29,508		5,726	4,708	16.0%		87		80		79		75		56		64		64		72
National (2011)							88		85		88		80		71		70		70		

Adult Consumer Satisfaction Survey 2012 SA Clients

Agency	Number Served FY2011		Number of Forms Returned 2011	2012	Percent of Clients Sampled		General Satisfaction		Good Service Access		Quality & Appropriateness of Services		Participation in Treatment Planning		Positive Service Outcomes		Social Connectiveness		Improved Functioning		Wellness	
Bear River Health Dept.	1,248		139	151	12.1%	→	72	↓	76	→	89	↓	68	→	78	→	84	→	81	→	86
Central Utah	252		46	20	7.9%		*		*		*		*		*		*		*		*
Davis Behavioral	849		186	168	19.8%	↑	89	→	82	↓	87	↑	84	→	86	→	86	→	86	→	91
Four Corners	548		82	128	23.4%	→	80	↓	81	↓	82	↓	73	→	77	→	84	→	81	↓	81
Northeastern	470		144	144	30.6%	→	73	↓	75	↓	75	→	65	↓	48	→	80	→	76	↓	77
Salt Lake Co.	5,950		1,502	1,247	21.0%	→	83	→	80	→	79	→	76	→	73	→	82	→	79	→	79
San Juan	125		13	13	10.4%	↓	69	↓	69	→	92	→	92	↓	69	→	85	→	77	→	85
Southwest	541		96	76	14.0%	↓	84	→	76	↓	87	→	82	→	82	→	84	→	86	→	90
Summit Co. - Valley Mental Health	221		80	62	28.1%	→	85	→	69	↓	79	→	69	↓	64	→	84	↓	69	↓	76
Tooele Co. - Valley Mental Health	396		180	82	20.7%	→	72	→	77	→	83	→	75	↓	58	→	90	→	73	→	86
U of U	358		31	40	11.2%	→	100	→	90	→	95	→	83	→	78	→	98	→	90	→	100
Utah County Substance Abuse	998		412	478	47.9%	→	83	→	80	↓	80	↓	70	→	78	→	84	→	85	→	85
Wasatch Co. - Heber Valley Counseling	81		29	29	35.8%	→	97	→	97	→	93	→	83	→	93	→	97	→	97	→	93
Weber	1,013		237	253	25.0%	↓	85	↓	84	→	89	→	75	→	83	→	89	→	87	→	90
State	12,908		3,177	2,891	22.4%		83		71		81		74		76		84		76		84
National (2011)							88		85		88		80		71		70		70		

H. Trauma

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

In December, the Utah Department of Human Services (DHS) conducted a two day training/Planning Session with Dr. Stephanie Covington designed to be the first step towards adopting Trauma Informed Care Principles across all DHS Divisions including— The Division of Substance abuse and Mental Health (DSAMH), Division of Child and Family Services (DCFS), Division of Juvenile Justice Services (JJS), and the Division of Services for People with Disabilities (DSPD). DHS anticipates that this will become an ongoing process and that these trainings/planning sessions will continue for the foreseeable future. Additionally, the DHS is undertaking a broad Systems of Care Integration Project lead by the DHS's Director and the Division Directors, the Trauma Informed Care Initiative has been rolled into that initiative.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?

As part of the DHS's System of Care initiative, the DSAMH is in the process of planning a statewide system training and planning session for Mental Health and Substance Use Disorder providers to:

a. Improve trauma awareness in the provider network;

b. Plan for ways to implement trauma informed care across the state system; and

c. Begin a long term systemic transformation to a trauma informed, recovery oriented, gender responsive and culturally competent system of care.

This will be the first step of a process that is estimated to take at least three years. It is envisioned that Dr. Covington or her staff will be utilized in at least one of the initial trainings with the Local Authority Directors

and their key clinical staff. Implementation after that will be based on plans developed by each local authority.

2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?

In addition to the process outlined above, for the past four years the DSAMH has conducted a statewide training for clinicians to improve their ability to identify and treat trauma. This has included trainings on TREM, Stephanie Covington's trauma informed care, Seeking Safety, and trauma informed care for veterans. The DSAMH will continue to conduct these trainings into the foreseeable future. The DSAMH also anticipates offering multiple workshops and keynote speakers on the topic of trauma informed care at our 2013 Fall Conference. Key note speakers include Tonier Cain and William Killebrew. Finally, the DSAMH has invited Dr. Stephanie Covington to present at our Drug Court Conference in October

3. Does your state have any policies that promote the provision of trauma-informed care?

See Above.

4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?

See Above.

5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

See Above.

I. Justice

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas. [42,43] Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.[44]

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

At this time, Utah is still determining whether or not they want to participate in the optional adult Medicaid Expansion. The Governor has indicated he will make a decision sometime in late September and the funding

to move forward with this program would need to be approved by the State Legislature, which will convene in late January of 2014.

Utah has received approval from the US Department of Health and Human Services (HHS) to operate a "bifurcated" Health Insurance Exchange (Marketplace). This means that the Utah will have a federally operated Individual Marketplace and a State operated small business Marketplace. The State small business Marketplace, is currently in operation, and is known as Avenue H. Additionally, as a part of the "bifurcated" model, Utah was given authority to maintain regulatory authority of Qualified Health Plans (QHP) on both the federal and state marketplace. This means that the Utah Department of Insurance will be responsible for the certification of QHPs on both the federal and state marketplaces.

During the 2013 Interim Legislative Session, Utah selected its Essential Health Benefit (EHB) benchmark plan. This plan was approved by HHS, despite it not meeting all of the requirements of the Affordable Care Act (ACA). Specifically, the EHB Utah selected does not meet the ACA's standards for ensuring mental health parity for substance use disorder and mental health benefits and it does not meet the standards established for child pediatric vision and dental benefits. The Utah Department of Insurance has acknowledged that the selected plan does not meet mental health parity requirements and have indicated that during the certification process of QHPs they intend to enforce parity, but have not offered specifics on how they will achieve parity.

Due to the uncertainty that these issues create, many of the answers provided will be conditional and subject to change.

Currently DSAMH contracts with the 13 local authorities to provide treatment in 44 certified drug courts, where state funds are allocated to provide treatment, drug testing, and case management services. The Administrative Office of the Courts also receives funding for court costs. Additionally, some of our local authorities partner with mental health courts in their region, although neither the DSAMH nor the local authorities provide any direct funding to this program.

The DSAMH is working to change current Medicaid rules so that individuals who are jailed or in treatment will not have their Medicaid eligibility revoked, but only have it suspended, so that it is available immediately upon release from incarceration. The DSAMH will continue to work to simplify rules so that coverage is as seamless as is possible.

In accordance with Utah Code 17-43, the Counties are responsible for planning for and providing services to their population, "including substance abuse needs and services for individuals incarcerated in a county jail or other county correctional facility". Because of that, the services provided to inmates vary with the priorities of each county government and their designated local substance abuse and mental health authorities. All Local Authorities provide some services for individuals within the criminal justice system (CJS); however, the individuals in the CJS requiring services are greater than the resources available to the local authorities to provide those services.

By state statute any individual who is charged with a Driving under the influence (DUI) of drugs or alcohol is required to receive a screening prior to their case being adjudicated. If the screening indicates the likelihood of a SUD, then a full assessment is required. If no SUD is present, then Prime for Life education is required. If an SUD is present, then the sentence will include an order to complete the treatment recommended by the assessment.

The DSAMH has a long history of cooperation with the Department of Corrections and with the Administrative Office of the Courts to provide services through a variety of programs aimed at the criminal justice population. These include Drug Courts, Drug Boards, Mental Health courts, the Drug Offender Reform Act, technical assistance to the prison treatment system, and close cooperation between the local authorities and their local County Sheriffs.

The Division provides scholarships to The Utah Generation's conference and Fall Substance Abuse Conference to individuals in the criminal justice profession. The Fall Substance Abuse Conference has an entire track dedicated to the treatment of individuals involved in the criminal justice system. Additionally, the Division hosted a Drug Court conference in 2012 and plans an additional conference in 2013, to educate drug court personnel on the latest information and evidence on effective treatment in a drug court setting.

J. Parity Education

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?

The Utah Division of Substance Abuse and Mental Health (DSAMH) will continue to use the administrative portion of the behavioral health care block grant funds to work with other state agencies to ensure that parity is well understood and the importance of including behavioral health care services in any state plan. During the past year, DSAMH staff have met on an almost weekly basis with Legislative Committees, Local Authority Directors and staff, other state agencies, county officials and other public partners to educate and advocate for full parity for behavioral health care services. Due to the active and vocal involvement by the DSAMH in these forums, the decision to adopt the state benchmark plan was made with the knowledge that it did not meet parity requirements. There is clearly awareness at the state executive and legislative level of the requirements, but along with other parts of the implementation process, the state is awaiting further guidance.

2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?

DSAMH will continue to use the administrative portion of the behavioral health care block grant funds to educate all public and private sector entities on mental health parity.

3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

The DSAMH continues to educate state and local partners on mental health parity. SAMHSA can assist these efforts by ensuring that the US Department of Health and Human Services issues clear guidance on how states should implement parity legislation and ensure Qualified Health Plans are compliant with parity requirements.

K. Primary and Behavioral Health Care Integration Activities

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

At this time, Utah is still determining whether or not they want to participate in the optional adult Medicaid Expansion. The Governor has indicated he will make a decision sometime in late September and the funding to move forward with this program would need to be approved by the State Legislature, which will convene in late January of 2014.

Utah has received approval from the US Department of Health and Human Services (HHS) to operate a "bifurcated" Health Insurance Exchange (Marketplace). This means that the Utah will have a federally operated Individual Marketplace and a State operated small business Marketplace. The State small business Marketplace, is currently in operation, and is known as Avenue H. Additionally, as a part of the "bifurcated" model, Utah was given authority to maintain regulatory authority of Qualified Health Plans (QHP) on both the federal and state marketplace. This means that the Utah Department of Insurance will be responsible for the certification of QHPs on both the federal and state marketplaces.

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?

The Utah Division of Substance Abuse and Mental Health (DSAMH) has promoted a focus on health and recovery in both Substance Use Disorder (SUD) and Mental Health (MH) services for at least five years. As such, the DSAMH leadership has been at the table for virtually every meeting regarding integrating expanding health care and implementing health care reform. The DSAMH has spearheaded efforts in legislative meetings to include behavioral health care in all plans for expansion, if in fact the state decides to expand Medicaid.

2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?

The Division has worked closely with the Department of Health (DOH) on several issues during the past five years. Those issues include Prescription Drug overdoses, Fetal Alcohol Syndrome, Drug Endangered Children, and most recently, Tobacco Cessation. (see question 4 below).

Most recently the Division and the DOH met to review opportunities to collaborate on other health related issues that affect both BH and Physical Health care providers. There is significant energy towards coordinating our efforts towards reducing the impact of co-occurring chronic health care conditions on both systems through coordinated care. Likewise, there is a statewide effort by the DOH and partner agencies to apply for an innovations grant to implement further integration activities.

3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?

Yes, the Division has provided training at both the state level and local level on integrating behavioral health care with primary health care, and two of the Local Authorities have already established pilot programs. Due to the statutory requirements that the Division must comply with, Local Authorities are the key agencies in the decision to initiate new processes and programs. The state is providing, and will continue to provide education, encouragement, and support to new initiatives that the local authorities have developed. The state has limited authority to mandate new programs, and due to the diverse nature of the state's population and geography, state wide mandates need to be carefully considered. Where establishment of a health care clinic inside the Local Authority's main office makes sense in Weber Human Services, that provides services to a county of 234,000, it makes much less sense in Sevier County, with a Population or 21,000 and three times the area

4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.

In 2009, the Division began a partnership with the Department of Health to implement tobacco free policies in all publicly funded SUD and MH facilities. Dubbed "Recovery Plus", the program set out a three year plan for all agencies to become Tobacco Free by March 2013. The three year plan included and assessment phase, an education and policy development phase, and an implementation phase. While it has not yet

been fully implemented in all areas of the state, the requirement is that all publicly funded programs have policies in place. There are two requirements that were the backbone of the program: first, that no individual be denied services because of their tobacco use, and secondly, that all individuals be given assistance in quitting their tobacco use.

More information about Recovery Plus can be found at http://recoveryplus.utah.gov/**.**

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.

"Recovery Plus" requires that tobacco use be assessed at admission, and nicotine use be included in the diagnosis when appropriate. Under a grant jointly administered by the DOH and DSAMH, several CO monitors were purchased and provided to agencies requesting them, and the DOH provided funding to purchase Nicotine Replacement Therapy supplies to assist individuals admitted to residential facilities while they enrolled in Utah's Tobacco Quit Program. More information about Recovery Plus can be found at **http://recoveryplus.utah.gov/**.

6. Describe how your behavioral health providers are screening and referring for:

a. heart disease,

b. hypertension,

c. high cholesterol, and/or

d. diabetes.

In 2008, the Division Directive for FY 2009 required that the Local Mental Health Authorities implement a "Wellness Directive" that included the following guidance:

"The division has embraced two guiding principles in its effort to promote recovery:

- Recovery includes WELLNESS; and
- Overall health is essential to mental health.

Because of the premature mortality rate of seriously mentally ill persons, 25 years earlier than non-mentally ill persons, include in your area plan the how you plan to incorporate physical health care issues in the overall treatment planning for adults.

*The following suggestions are taken from a report published by the National Association of State Mental Health Program Directors (MASMHPD) Medical Directors Council titled "Morbidity and Mortality in People with Serious Mental Illness," **www.nasmhpd.org** October 2006:*

- monitoring weight
- diabetes screening
- tobacco use
- provide training for staff in recognizing health issues
- the adoption of policies to ensure integration of mental health and physical health care
- providing information to consumers on physical health concerns and ways to improve their physical health
- how to incorporate wellness into individual person-centered plans
- how the center will improve prevention, screening and treatment in context of better access to health care
- identified a specific practitioner to be the responsible party to ensure that each person's medical health care needs are being addressed"

This directive has remained in place since that time. While the SUD services have been slower to adopt the guidance, largely due to the lack of medical personnel in the SUD provider network outside of the combined centers, the general approach to treating the whole person has long been an element of SUD assessment and treatment planning. Across the state system, Recovery Plus has been promoted as part of the overall wellness approach to recovery planning, rather than a specific service.

The 2014 Division Directive, the following language was included:

Substance Use Disorder Treatment

vi. Wellness: a. Local Authorities will use a Holistic Approach to Wellness and will:

1. *Identify tobacco use in the assessment.*
2. *Provide services in a tobacco free environment.*

3. *Implement a protocol for identification and referral for screening and treatment of HIV, Hepatitis C and TB.*
4. *Evaluate all clients who are opioid or alcohol dependent for the use of Medication Assisted Treatment.*
5. *Provide training for staff in recognizing health issues.*
6. *Provide information to clients on physical health concerns and ways to improve their physical health.*
7. *Incorporate wellness into individual person centered Recovery Plans as needed.*

vii. Local Authorities will cooperate with efforts of the Division of Substance Abuse and Mental Health to promote integrated programs that address an individual's substance abuse, mental health, and physical healthcare needs, as described in UCA 62A-15-103 .

Performance Measures

g. Tobacco Cessation: Local Substance Abuse Authorities' scorecard will show that the percent of clients who use tobacco will decrease from admission to discharge."

Mental Health

vi. Local Authorities will use a Holistic Approach to Wellness. Local Authorities must provide and as appropriate document the following:

a. Monitor weight (and height for children).

b. Provide or arrange for a diabetes screening, as indicated.

c. Identify tobacco use in the assessment.

d. Provide services in a tobacco free environment.

e. Provide training for staff in recognizing health issues.

f. Cooperate with efforts of the Division of Substance Abuse and Mental Health to promote integrated programs that address an individual's substance abuse, mental health, and physical healthcare needs, as described in UCA 62A-15-103.

g. Provide information to clients on physical health concerns and ways to improve their physical health."

h. Incorporate wellness into individual Recovery Plans as needed.

L. Health Disparities (Block Grant Guidance is in Blue)

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?

The Utah Division of Substance Abuse and Mental Health (DSAMH) collects extensive data on individuals receiving services throughout the state in the Substance Abuse and Mental Health Information System (SAMHIS). Using data the data in SAMHIS the DSAMH can identify services by local authority, the typ of service provided, client demographics including—gender, race, ethnicity, and primary, secondary, and

tertiary diagnosis. Currently the state does not collect information regarding sexual orientation or language, nor is it clear that attempting to collect information at the state level would result in accurate and usable information, especially in more rural areas.

By Statute and Rule, the Counties, organized into Local Authorities, are responsible for planning for and providing services to their residents. The local planning and control that results from this system allows the maximum flexibility for each area to determine the needs in their area and plan accordingly. This allows San Juan County to focus on the Native American population on the Navaho Reservation; South West Behavioral Health Care to focus on the Hispanic population in St. George and the Native American groups in Cedar City; and Salt Lake County to provide diverse services to the extensive LGBTQ population that have found a haven there.

In accordance with State Statute, each Local Authority has to submit an annual Area Plan outlining their plan to provide services. This plan is based on their assessment of treatment needs in their area and their prioritization of programs to meet those needs. The Area Plan is reviewed by the DSAMH staff for compliance with the Statutes, Rules, Contract Language, and the Annual *Division Directives*; if necessary, Area Plans are returned to the Local Authority for revision.

During the annual Audits of each Local Authority, their operations are reviewed for compliance with their Area Plan as well as with contract and other Division requirements. Of prime importance in both the review of the Area Plan and the audit of a Local Authority's performance, is the provision of services to the specific population in their service area. This is measured by a review of the data, as well as through interviews with clients and community partners.

2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?

The DSAMH does not have this capability at this time, and sees this primarily as a function of each local authority.

3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity vulnerable subpopulations?

The DSAMH will continue to monitor Local Authorities compliance with the Division Directives and Contracts and monitor their area plans for these issues.

4. How will you use Block Grant funds to measure, track and respond to these disparities?

If Block Grant funds become available through the adoption of Medicaid expansion or other behavioral health funding becomes available, then the DSAMH will determine what funding is available to measure, track and respond to disparities that exist. Currently, Block Grant Funding doesn't come anywhere near the needed level to provide the services needed for mandated services.

M. Recovery (Grant Guidance is in Blue)

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

Yes, the Utah Division of Substance Abuse and Mental Health (DSAMH) is incorporating the concepts of Recovery into both mental health (MH) and substance use disorder (SUD) services for the past four years. In 2011 Peer Support Specialists (PSS) services were added to the State Medicaid Plan and the DSAMH began conducting quarterly MH PSS trainings. In 2012, House Bill 496 was passed, which gave the DSAMH the authority to develop rules for a SUD Peer Support Specialist. That rule has been developed (R523-2) and can be found at: http://www.rules.utah.gov/publicat/code/r523/r523-002.htm

In addition, the DSAMH formed an SUD Recovery Oriented System of Care (ROSC) Workgroup that has been meeting for the past three years to expand traditional clinical acute care SUD services into a true ROSC. That has been expanded to include the Performance Development Committee, the Clinical Committed and the Finance Director's committee of the Behavioral Health Care committee, which is the Provider Organization for the State. This has been reinforced by workshops and presentations at the Utah Substance Abuse Fall conference for the past three years, where innovative practices that support Recovery Support Services and activities are highlighted. Additionally, use of the Access to Recovery (ATR) funds has greatly expanded the ability of the DSAMH to provide Recovery Support Services.

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

The DSAMH is bound by State statute and rule on hiring practices, so formal documentation of a person's Recovery status is not allowed as part of the hiring process. However, this writer and over twenty percent of the DSAMH staff are in recovery themselves or have family members in recovery. The DSAMH is currently recruiting for a Peer Support Program Manager, and due to the specific requirements for the position, additional points have been incorporated into the scoring for an individual who has either a personal or family related recovery history.

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

The DSAMH moved to a Person Centered Planning system in MH five years ago, and the SUD system has adopted the principles of person centered care and is in the process of changing the SUD Practice Guidelines to reflect person centered planning and individualized care. For the past year, the DSAMH staff have been working with the Utah Behavioral Health Care Clinical Committee to develop principles to guide the documentation and practices around assessment, treatment planning and treatment. The Division Directive has this specific language included:

i. Substance Abuse Treatment Local Authorities will provide services that comply with the following principles:

a. Initial Engagement: (These principles are shared with Mental Health Treatment.)

1. *Focus is on the immediate/pertinent needs of the client.*
2. *Clinician establishes rapport with clients.*
3. *Clients can expect to gain something (relief, clarity, answers, hope) from the initial engagement session.*
4. *Clinician's check that client's needs are being met.*
5. *Clinician's gather and document relevant information in an organized way.*
6. *Clinicians make recommendations and negotiate with and respect the client.*
7. *Ongoing Assessment: (These principles are shared with Mental Health Treatment).*
8. *Assessment information is kept current.*
9. *Clinicians gather comprehensive relevant assessment information based on the client's concern in an ongoing manner as part of the treatment process.*
10. *Assessment includes an ongoing focus on strengths and supports that aid in their recovery.*

11. *Assessment includes identifying those things that motivate the client and how those motivations have been impeded by mental illness and/or addiction.*
12. *Assessment information is organized coherently and available in a readable, printable format.*

c. Recovery Planning Principles:

1. *The client is involved in ongoing and responsive recovery planning.*
2. *Plans incorporate strategies based on the client's motivations.*
3. *Where possible, the plan represents a negotiated agreement.*
4. *The plan is kept current and up to date.*
5. *Short term goals/objectives are measureable, achievable and within a timeframe.*
6. *Planning anticipates developing and maintaining independence.*

d. Treatment Principles:

1. *Treatment is individualized dynamic and adjusts according to feedback and concerns of the client*
2. *Treatment is recovery focused and based on outcomes, sound practice and evidence.*
3. *Family and other informal and natural supports are involved as approved by the client.*
4. *Treatment is provided in a culturally competent, gender appropriate and trauma informed manner.*

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

The DSAMH has used the Access to Recovery (ATR) grant to expand services in three of the most populated counties, and to expand their use of contracted providers. This has been expanded to the fourth most populated county, and the ATR Voucher system has also been adopted and funded by the Department of Corrections to provide Recovery Support Services to their clientele. This has assisted the state's ability to move forward in treating addiction as a chronic illness, but the lack of funding for priority populations restricts the diversion of funds from primary treatment to Recovery Support Services. The DSAMH is moving forward in expanding Peer Support Services, and has provided support through contracts to both the Utah

Chapter of NAMI and to Utah Support Advocates for Recovery Awareness (USARA) to provide education and recovery support services to clients and their families.

5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

The DSAMH is just developing PSS services and training, and will work to train PSS to be culturally competent, trauma informed, and able to provide gender specific services. However, the actual provision of those services will be provided by the Local Authorities who are best able to target limited resources to the needs of their area. MH PSS training has been made available to the Veterans Administration, the Navaho Tribe, and to all of the local authorities.

6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?

Yes, the DSAMH provides training to the local mental health authorities and other community partners and stakeholders on recovery principles and recovery-oriented practice systems. The DSAMH provided training to the VA, the Navaho Tribe, and to all local authorities for mental health PSS.

7. Does the state have an accreditation program, certification program, or standards for peer-run services?

Yes, the Utah Division of Substance Abuse and Mental Health (DSAMH) is incorporating the concepts of Recovery into both mental health (MH) and substance use disorder (SUD) services for the past four years. In 2011 Peer Support Specialists (PSS) services were added to the State Medicaid Plan and the DSAMH began conducting quarterly MH PSS trainings. In 2012, House Bill 496 was passed, which gave the DSAMH the authority to develop rules for a SUD Peer Support Specialist. That rule has been developed (R523-2) and can be found at**:** http://www.rules.utah.gov/publicat/code/r523/r523-002.htm

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

DSAMH established a Recovery Oriented System of Care Workgroup in 2009 that has continued its work through the present. While it was solely a SUD focused project at the beginning, it has morphed into a combined SUD and MH workgroup that meets under the auspices of the Utah Behavioral Health Care Clinical committee prior to its monthly meetings. This workgroup has focused its efforts on a cultural shift from an acute care model to a chronic model with a broad spectrum of prevention and treatment interventions. This workgroup has led to the development of similar workgroups of Finance Managers and Data Managers. Some of the accomplishments of the workgroup have been:

1. Encouragement and support of pilot projects using a limited treatment identifier in the SAMHIS data system enabling agencies to discharge a client in TEDS but continue to provide Recovery Support Services after the acute treatment episode.
2. Use of the same identifier to track clients who receive specific indicated prevention interventions to track their progress in the system.
3. Use of case managers to maintain liaison with clients post discharge.
4. Intensive efforts to disseminate creative approaches to person centered care and ROSC during the annual Fall substance Abuse Conference.
5. Revision of the initial intake, assessment, treatment planning, and treatment processes focused on person centered care rather than program centered care. This has culminated in the revision of the DSAMH SUD Practice Guidelines.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

The Utah Division of Substance Abuse and Mental Health (DSAMH) reviews each of the Local Authorities annual Area Plans to ensure they are compliant with the requirement they include family members and individuals in recovery and the degree to which they include family members in the treatment process.

DSAMH relies heavily on input from the main Recovery Organizations in the State, NAMI-Utah and USARA, in planning for and providing these services. Additionally, a Division Consumer Advocate Specialist in Recovery serves as an invaluable resource to family members. Finally, the DSAMH supports and funds a Family Resource Facilitator for each Local Authority. This individual is an invaluable asset to the family and provides assistance to accessing services.

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

The DSAMH has had a contract with USARA for the past five years to provide support for individuals and family members in recovery from Substance Use Disorders. Additionally, the Division is expanding its Health Care Advisory Council from solely a Mental Health Care Council to a combined Mental Health and Substance Use Disorder council, which meets monthly.

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

Local Authorities are required to have their area plans reviewed by their county governments and many are required to hold public hearings on their area plans. The DSAMH does not solicit public input on state wide programs and initiatives, the decentralized nature of planning for services mandated by state statue and rule means there are differences among the Local Authorities based on population, level of involvement and county priorities. The DSAM requires that each Local Authority include projected Recovery Support Services in their Area Plans.

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

The DSAMH is very supportive of those activities. Along with previously discussed contracts and involvement, DSAMH has funded Family Resource Facilitators for each Local Authority, and involves them in planning and assistance visits, as well as in planning for services.

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?

DSAMH is supportive of each Local Authority's efforts in this area. Salt Lake Weber and Davis Counties have significant homeless populations and have significantly expanded their efforts to provide supportive housing and develop transitional housing programs for this population. In more rural areas like Central Utah, efforts are more individualized and isolated. The DSAMH is involved in several supportive housing initiatives and chairs a sober housing committee which is part of the Utah Substance Use Advisory Council's Behavioral Health Care Workgroup. This multi-agency committee is working with local governments and state agencies to develop rules and standards for supportive recovery housing.

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?

See Above.

N.1. Evidence Based Prevention and Treatment Approaches for the SABG

As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities

to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

All programs are categorized within an IOM and CSAP 6 and tracked in our data tracking system to collect process data for reporting each fiscal year. Minimum Data Set (MDS) is federally mandated tracking system designed by CSAP and managed by DCAR and used to identify specific prevention services that has been rendered to the clients. The system is designed to record state data for each service and archived for reporting. MDS is designed to log the demographics, description of service and sessions of the Single or Recurring reported services. Reports for the programs can track how often the programs are delivered and to what population. MDS helps our state to maintain records of services to evaluate the effectiveness of services including the frequency, intensity, and duration of the used to identify specific prevention services that has been rendered to the clients. The system is designed to record state data for each service and archived for reporting. MDS is designed to log the demographics, description of service and sessions of the Single or Recurring reported services. Reports for the programs can track how often the programs are delivered and to what population. MDS helps our state to maintain records of services to evaluate the effectiveness of services including the frequency, intensity, and duration of the program, policy or practice. MDS also allows our state to effectively track our programs within the six CSAP strategies for primary prevention regarding, Information Dissemination, Education, Alternatives, Problem Identification and Referral, Community Based Process, Environmental for individuals, schools, parents, and communities, so these target populations can receive an appropriate range and variety of prevention services that encompass both single and recurring services.

Each Local Authority uses Strategic Prevention Framework (SPF) developed by the Substance Abuse Mental Health Services Administration (SAMHSA) to implement comprehensive community level prevention systems within their area. DSAMH encourages LSAA to utilize the Communities that Care model to meet this directive. Each LSAA then follows the SPF to plan and implement that process.

1. Assess local prevention needs based on epidemiological data. This assessment shall include the most current Student Health and Risk Prevention Survey (SHARP) data.
2. Build prevention capacity, including assurances that all prevention personnel are certified and trained for implementation and delivery for all required programs.
3. Develop a strategic plan.
4. Implement effective community prevention programs, policies and practices.

5. Use logic models as the basis for evaluation plan and to demonstrate expected short and long term outcomes.

6. Submit an annual report that summarizes performance of prevention programs policies and strategies based on the short and long term outcomes identified in the logic models.

7. LSAA shall spend a minimum of 30% of SAPT Block Grant funds on prevention policies, programs, strategies, administration.

Evidenced-Based Indicated Prevention

A. Block grant funding will be used for, but not limited to the development, expansion or enhancement of prevention programs to help meet or maintain evidenced-based standards. Programs, strategies and services listed on one of the following registries shall be considered eligible:

1. Center for the Study and Prevention of Violence- Blueprints **http://www.colorado.edu/cspv/blueprints/**;
2. U.S. Department of Justice Model Programs Guide **http://www.ojjdp.gov/mpg/**;
3. Communities That Care Prevention Strategies Guide **http://www.sdrg.org/ctcresource/**
4. Programs determined by the Utah Evidence Based Workgroup to be Level III: Supported, Efficacious Practices, or Level IV: Well Supported- Effective Practices using the Program Assessment Rating Tool (PART) developed by the Office of Child Abuse and Neglect (OCAN).

5. National Registry of Evidence-Based Programs and Practices

http://www.nrepp.samhsa.gov/ (More attention will be given to those programs that have been verified through an evidenced process and can be validated through other sites)

Allowable expenses will be limited to:

1. Promotion of selected program(s)
2. Evidence-based program (EBP) program training and certification
3. Purchase of consumables and materials required to deliver EBP
4. Implementation (Direct staff time devoted to preparation and delivery of EBP)
5. Monitoring and evaluation
6. Other expenses necessary to promote, implement, enhance or bring EBP to fidelity.

The Local Substance Abuse Authority agrees to the following:

1. Implement services as described by EBP program curriculum
2. Monitor implementation of program to ensure critical elements are delivered as described by program developer (fidelity)
3. Collect process data and report on DSAMH approved data collection system (MDS)
4. Administer approved pre-post matched surveys to participants.
5. Provide matched Pre/Post tests to each program participant
6. Ensure all services are delivered by individuals certified and/or licensed for the implemented program
7. Ensure that providers are Substance Abuse Prevention Specialist Training certified

2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

Prevention Dimensions, Implementation of Student Health and Risk Prevention Survey, (SHARP) and other data sources that provide data on targeted populations for adequate assessment of priorities and risks. SAPST and CTC training to ensure all prevention professionals are trained and use above mentioned process for demonstrating effective outcomes.

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

We will use a comprehensive strategy that involves the above-mentioned process from question one as well as coalition building and collaboration of resources where necessary. Each LSAA district will have at lest one coalition where staff and volunteers are representative of the needs and resources including DWS.

4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

Each LSAA develops a strategic plan and implement effective community prevention programs, policies and practices. The basis for evaluation is the use of logic models to demonstrate expected short and long term outcomes. The LSAA will also submit an annual report that summarizes performance of prevention programs

policies and strategies based on the short and long term outcomes identified in the logic models. The results of these data will then be reviewed, presented and discussed with each LSAA coordinator for changes to next year's plan as needed.

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

Budgets from each LSAA are submitted each year to match the allocation of funding from DSAMH. The details of these budgets categorize the programs, strategies and policies in the IOMs and CSAP 6 and then monitored throughout the state fiscal year as well as a formal annual audit.

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)

The prevention total for FY13 was $3,220,663 or the total of 20% of the entire BG. $483,099 remained with DSAMH for administration, research-evaluation, training and collaboration while $2,737,564 was allocated to the 13 LSAA or communities to follow the above-mentioned process from question one. (The numbers for FY14 are not available at this time)

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

An estimated $362,324 is used on the following programs: Prevention Dimensions, a K-12 substance abuse prevention program that's implemented state-wide, SHARP Survey, SAPST and CTC trainings.

N.2. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

The Division of Substance Abuse and Mental Health (DASMH) created a competitive three year RFP with the vision of individuals, families and communities working together, using existing resources as well as additional skills to promote mental health and prevent mental illness. The first year of the RFP is broken into two parts, with part one of RFP focused on keeping the traditional advocacy, support, wellness, education, and consultation services in place. Part two of the RFP requires the recipient to complete a statewide needs assessment based on the Communities that Care model. The assessment tools utilized are evidenced based models for prevention activities. In year two, based on the outcomes of the needs assessment, the recipient would submit a plan for mental health promotion and mental illness prevention, including early intervention and suicide prevention. A guiding principle of DASMH was not to create a new workforce; instead the contractor would be required to send funds through the local community substance abuse prevention coalitions. In year three the plan would be implemented by the local substance abuse prevention coalitions with ongoing evaluations.

O. Children and Adolescents Behavioral Health Services (Grant Guidance is in Blue)

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Utah is in a very good position to expand System of Care statewide for children and youth from birth to age 21 and their families, regardless of their insurance coverage. This level of readiness is based on previous and current efforts in service delivery and infrastructure development:

a. System of Care Expansion and Planning Grant, 2012 – Present (SAMHSA funding): DSAMH collaborates with the Division of Child and Family Services (DCFS), Division of Juvenile Justice Services (DJJS), and Division of Services for People with Disabilities (DSPD) to develop a comprehensive statewide strategic plan to improve and expand services using a system of care approach for children and youth from birth to 21 years of age who have, or are at risk of developing, serious mental health conditions. The comprehensive strategic plan will address the issues of:

i. Policy, Administrative and Regulatory Changes

ii. Developing Services and Supports based on System of Care Philosophy and Approach

iii. Financing

iv. Workforce Training, Technical Assistance and Coaching

v. Generating Support and Advocacy to Drive Implementation

vi. Social Marketing, and

vii. Cultural Competency

b. Statewide Family Resource Facilitation, 2007 – present: Family Resource Facilitators (FRF) are family members trained to provide resource facilitation and family to family support services. FRFs receive additional training, supervision, and mentoring to become wraparound Facilitators so they may facilitate wraparound services to children and youth with complex needs.

Through the braiding of state funding and Block Grant, there are currently 42 Family Resource Facilitators (FRF) throughout the state to provide family support services to children, youth, and families regardless of their insurance coverage. Within the public mental health and substance abuse system, these FRFs are stationed (or located) in every mental health/substance abuse provider agency. There are also FRFs stationed in the child welfare and juvenile justice systems.

c. Healthy Transitions Initiative, 2009 – present (SAMHSA funding): This initiative provides services to support young people between the ages of 16 and 25 with serious mental health challenges to successfully transition into adulthood. It is implemented in two rural/frontier counties, each with two American Indian tribal governments within the catchment area.

d. Child and Adolescent State Infrastructure Grant, 2004 – 2010 (SAMHSA funding): DSAMH engaged in statewide strategic planning, including the seven tribal governments, to improve the state's infrastructure in children's mental health and substance abuse services. It focused on evidence-based practices (EBP), technology, cultural competency, and financing. Through this project, DSAMH implemented pilot projects integrating behavioral health services in school and primary care settings.

e. Partnership for Youth Transition, 2002 – 2006 (SAMHSA-funding): This project uses the System of Care principles to develop a model to assist young people between the ages of 14 and 21 and with emotional and

behavioral disorders to successfully transition into adulthood. It was implemented in four urban counties.

f. Children's Mental Health Initiative, 1998 – 2005 (SAMHSA funding): This initiative provides wraparound services for children with serious mental health conditions and their families in six rural/frontier counties. Although the evaluation demonstrated improved outcomes for both the children and their families, the SOC services were not fully sustained after the grant fund ended. However, through this initiative, DSAMH learned valuable lessons in implementing SOC and the sustainability challenges.

Through these projects, DSAMH built a strong foundation for statewide SOC expansion. DSAMH has also learned many lessons in evidence-based practices, consumer/family-driven and youth-guided approaches, cultural competency, financing and sustainability. DSAMH has always used lessons learned to improve subsequent projects.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

The Division's Children, Youth and Families team (CYF) helps shape the system of care through policy development, technical assistance, monitoring and oversight. In 2014, CYF plans to enhance the support of recovery and resilience of children and youth with mental and substance use disorders' system of care approach through following action steps:

a. Collaborate with the Divisions of Child and Family Services (DCFS), Juvenile Justice Services (DJJS) and Services for People with Disabilities (DSPD) to develop an integrated family and youth development plan across the four divisions. The plan will address issues of staff development and family and youth leadership training.

b. Support the Utah Family Coalition's effort to expand family involvement activities to child welfare and juvenile justice systems. Utah Family Coalition (UFC) is a network of family advocacy organizations that advance family-driven and youth-guided approaches. Members include Allies with Families (Utah chapter of the Federation of Families for Children's Mental Health), National Alliance on Mental Illness (NAMI) – Utah

Chapter, and New Frontiers for Families (a family advocacy organization for rural frontier communities). In 2013, UFC intends to increase family and youth representation from the child welfare and juvenile justice systems to create a greater reach of family and youth network to advance Utah's system of care approach. DSAMH will support UFCs effort by involving DCFS and DJJS in discussion on family and youth development.

c. Increase the number of Certified Family Resource Facilitators (FRFs). FRFs are family members who are trained to provide resource facilitation and family to family support services to children, youth, and families regardless of insurance coverage. The certification process includes initial 40-hour training, certification exam, on-going training, and 152 hours supervised practicum. In FY 2012, there were 15 FRFs throughout the state who completed the supervised practicum. By June 30, 2014, the Division plans to have 40 FRFs complete the supervised practicum.

d. Increase the number of Certified Wraparound Facilitators throughout the state to provide wraparound facilitation services to children, youth, and families regardless of insurance coverage. Certified FRFs receive additional 152 hours supervised practicum in wraparound facilitation to become Certified Wraparound Facilitators. In FY 2013, there are seventeen (17) Certified Wraparound Facilitators. By June 30, 2014, the Division plans to increase that number to 25.

e. Develop a Youth-in-Transition Certified Peer Support Specialist (CPSS) program: The Division is collaborating with the CPSS program to develop a supplemental training and supervision curriculum to support: i) young adults to become a CPSS, and ii) CPSS to develop the knowledge and skills to work with youth in transition age (15 to 26-years-old). In 2014, the Youth-in-Transition CPSS program will be piloted at a mental health/substance abuse center.

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

In FY 2013, there are several division directives that all contract providers have to adhere to: i) Strength-Based Assessment, ii) Person-Centered Recovery Plan, and iii) Holistic Approach to Wellness. Some key elements of these directives are:

The Strength-Based Assessment:

a. Will be an ongoing process with focus on the Initial Engagement and Ongoing Assessment.
b. The Initial Engagement:
1. Focuses on the immediate/pertinent needs of the client.
2. Establishes rapport between the client and the clinician.
3. Provides relief, clarity, answers, and/or hope for the client.
4. Allows for clinicians to check on client needs and if they are being met.
5. Documents relevant information in an organized way.
6. Allows clinicians to make recommendations and negotiate with and respect the client.
c. The Ongoing Assessment:
1. Keeps information current through clinician's ability to continue to gather new and relevant information.
2. Includes an ongoing focus on strengths and supports that aid the client in their recovery.
3. Addresses motivating factors and how they impact the client.
4. Is organized coherently and available in a readable, printable format.

The Person-Centered Recovery Plan:

a. Contains identifying information, diagnosis, and formulation
b. Documents treatment goals stated in the own words of the family and child and youth, when age and developmentally appropriate.
c. Contains a safety/crisis plan for child/youth and family when clinically indicated.
d. Identifies barriers to the achievement of goals.
e. Identifies anticipated transition/discharge criteria.
f. Provides copy of the plan to the child/youth and family.

g. Incorporates evaluation data (OQ or YOQ) into the decision-making process that either supports the current direction of the treatment plan or that suggest a change in direction, excluding children age five and under.

The Holistic Approach to Wellness:

a. Monitors basic physical health conditions (weight and height) of the child/youth
b. Provides training for staff in recognizing health issues
c. Provides information to child/youth and family on physical health concerns and ways to improve their physical health
d. Incorporates wellness into individual person-centered plans as needed
e. Provide prevention, screening and treatment in context of better access to health care
f. For child/youth who is on atypical medications:
i. Monitoring of labs, AIMS and tracking of vitals.
ii. Coordination/communication with prescribers.
iii. Emphasize exercise along with healthy leisure and recreational activities in youth programming.

DSAMH plans to monitor providers' adherence to these directive through annual on-site visit that includes records review, family focus groups, and staff interviews. For providers who perform at an unsatisfactory level, technical assistance plans will be developed to outline improvement strategies and timeline. For providers consistently perform at an unsatisfactory level, corrective actions will be developed for immediate attention.

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

Through the System of Care Expansion and Planning Grant, the Division established a SOC XP State Steering Committee to develop a comprehensive statewide strategic plan to improve and expand services using a system of care approach for children and youth from birth to 21 years of age who have, or are at risk of developing, serious mental health conditions. The State Steering Committee membership is diverse including public agencies, private organizations, community partners, advocates, and family and youth consumers.

The Division of Child and Family Services (DCFS), Division of Juvenile Justice Services (DJJS), Division of

Services for People with Disabilities (DSPD) actively participates on the Steering Committee to develop a strategic plan that addresses the issues of:

a. Policy, Administrative and Regulatory Changes
b. Developing Services and Supports based on System of Care Philosophy and Approach
c. Financing – A finance map outlining the four divisions' mental health/substance abuse services funding stream is developed.
d. Workforce Training, Technical Assistance and Coaching
e. Generating Support and Advocacy to Drive Implementation - DSAMH, DCFS, DJJS, and DSPD are in the process to develop an integrated family and youth development plan across the four divisions.
f. Social Marketing, and
g. Cultural Competency

DSAMH collaborates with the Utah State Office of Education (USOE) on several projects to institutionalize school-based mental health programming through:

a. Utilizing a Community of Practice model to improve the quality of school-based mental health programs,
b. Developing outcome measures to assess the effectiveness of school-based mental health programs provided by Local Mental Health Authorities.

By June 30, 2015, DSAMH plans to enhance the collaboration by:

a. Developing interagency agreements and partnerships for coordination of services and financing,
b. Identifying opportunities for long-term sustainable support of system of care infrastructure and approach,
c. Utilizing outcome data and evidence of cost savings or avoidance to promote investment in the expansion of the System of Care framework,
d. Identifying opportunities to inform state implementation of health care reform in support of System of Care principles and practices, and
e. Supporting the UFC in statewide leadership training for youth and family members to strengthen their abilities to advocate for system change.

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

Technical assistance is integrated into the annual monitoring site visits to local mental health and substance abuse centers. The Division works with each center to identify training subjects and consultants for the training. The Division co-sponsors the annual Critical Issues Conference (on children's mental health issues) and Generations Conference (on adult mental health issues) and organizes the annual Fall Substance Abuse conference. Evidence-based practices are an integral part of these conferences. Family and youth are invited to speak at these conferences to provide their perspectives and lived experiences in recovery and resiliency.

On June 20, 2013, DSAMH collaborated with DCFS and DJJS to organize the first annual "Transition Academy" that introduced a research-based transition facilitation model so the staff from the three divisions will provide transition services based on best-practice standards. The conference included presentations and discussions from individuals who have utilized the current services available and those who have expertise in various topics including housing, education, and community living skills.

Utah Department of Human Services (DHS) is leading an effort to transform the Department into a trauma-informed organization. In January 2013, DHS Executive Director's Office, DSAMH, DCFS, DJJS, and DSPD received training from Dr. Stephanie Covington on trauma-informed care. By June 30, 2014, there will be a DHS plan to provide trauma-informed care by DHS staff and providers. By June 30, 2015, a series of training on evidence-based trauma-informed care will be provided to all staff and providers of DSAMH, DCFS, DJJS, and DSPD. In order to accomplish these goals, Dr. Covington recommended that each Division develops a "Guide Team." Dr. Covington also recommended that the Executive Director's Office develops a Trauma-Informed Care Committee with a representative from each of the Guide Teams.

As part of the SOC XP strategic plan, DSAMH will collaborate with DCFS and DJJS to: a) identify relevant workforce training curricula offered by the three Divisions, b) conduct a review of existing curricula to identify sections reflecting information about children and youth with mental health needs, c) based on the findings, make recommendations to the three Divisions for possible adaptations to existing curricula to better align with System of Care principles and practices, and d) provide technical assistance in the adaptation of the training curricula and materials if requested. The three Divisions will also explore the feasibility to jointly develop a statewide training, technical assistance and coaching team/system that provides a unified approach to workforce development in evidence-based practices.

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Currently, DSAMH has a Scorecard on each Local Mental Health and Substance Abuse Authority with data on:

a. Number of children/youth served,
b. Estimate of need at 300% poverty,
c. # of SED served,
d. # of unfunded children/youth served,
e. # of children/youth served who are enrolled in school,
f. # of children/youth served receiving juvenile justice services,
g. Utilization of services,
h. Time in mandated services, and
i. Youth Outcome Questionnaire (YOQ) measures.

The utilization of services include inpatient (state hospital inpatient and community inpatient), residential treatment, and outpatient services (medication management, psychosocial rehabilitation, targeted case management, respite care, peer and family support services, assessment, and treatment therapy, emergency, school-based services, and in-home services).

P. Consultation with the Tribes

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Utah is home to 5 federally recognized American Indian Tribes including the Ute, Navajo, Piute, Shoshone and Goshute people. Our state's cultural diversity continues to expand with minority populations increasing from 2 percent to 20 percent of the total population over the last two decades. Additionally, Utah's Hispanic population continues to be the fastest growing community in the state. Compared to national averages, our population is younger and lives longer, has a higher birth rate, and currently Utah averages the highest number of persons per household. Due to the expanse of rural and frontier regions throughout Utah, some counties have joined together to provide services for their residents. Consequently, there are 29 counties in Utah (including 19 rural classified counties), and 13 local behavioral health authorities. By

legislative intent, with the exception of the Utah State Hospital, no substance abuse or community mental health center is operated by the State; the state does not provide clinical care.

Native American populations reside on tribal land throughout the state, primarily located in the Northeastern and Southeastern regions of the state. Federal, State, County and Native American jurisdictions are involved in providing services to this population. Both of these areas are relatively remote with poor transportation and sparse populations, which further stretch resources. The direct planning and provision of services is a responsibility of the Local Authorities in those areas, and the provision of services to Native American populations is a part of the annual contract review and audit. Success in negotiating service agreements and coordinating services is often an issue of local politics and personalities. Utah's Department of Human Services (DHS) has developed an intertribal council and signed a coordination/collaboration agreement with the various Native American tribal representatives supporting the need for planning and coordination at a state level.

While as stated above, planning for and providing services is a responsibility of the local authorities, Utah Division of Substance Abuse and Mental Health (DSAMH) has taken an active role in working with the Native American tribal organizations. This has included attendance at the quarterly DHS Intertribal Council and active discussions with the tribal authorities during the annual site visits to the local authorities. During the past year this has included presentations to the DHS Intertribal Council about the structure of the Behavioral Health Care system, and how the system is funded and organized. It included a discussion of the current statute and rules that guide the DSAMH in its operations. It also included a presentation to the entire DSAMH staff on the Native American Population and tribal organizations in Utah. There are ongoing efforts to include representatives from the tribal organizations on the Behavioral Health Consumer Advisory Council.

Q. Data and Information Technology (Grant Guidance is in Blue)

- **In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:**
- **Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;**
- **List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;**
- **Provide information regarding its current efforts to assist providers with developing and using EHRs;**
- **Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and**
- **Identify the specific technical assistance needs the state may have regarding data and information technology.**

Please provide an update of your progress since that time.

There are no updates or further progress on these items from last year.

R. Quality Improvement Plan

In the FY 2012/2013 Block Grant application, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

The Utah Division of Substance Abuse and Mental Health does not have a formal CQI plan. While the DSAMH does not have a formal CQI/TQM plan, both CQI and TCM concepts are integral to the way that DSAMH measures performance of its Behavioral Health Care Providers and how we monitor contract compliance. The DSAMH collects and utilizes extensive data on the "health of the mental health and addictions systems." Some of the ways we use this are described below.

The DSAMH uses a variety of scorecards measuring for all publicly funded behavioral health services. These documents allow the State to monitor and audit providers by tracing penetration rates, amounts of service, duration of services, trends, comparisons to other providers, etc. In the spirit of efficient and effective systems as defined in the good and modern guidance, Utah believes this scorecard an effective use of data. These scorecards compare the Local Authorities on their performance and are provided to the County governmental officials and are publicized on the DSAMH website. Targets for each performance indicator are published in the Division Directive and attainment of those targets is reviewed during each contract compliance review.

Targets are based on meeting National norms, improvement on past performance, and/or reaching a set level of performance and maintaining that standard. The score cards are color coded for easy reading. They indicate successful achievement (green), improvement needed (yellow), or performance below the state standards (red). Copies of the Mental Health and Substance Abuse scorecards are attached.

Additionally, Consumer Surveys are distributed each year and a consumer report card is also published, comparing the Local Authorities on their results. The reports are broken down by substance abuse and

mental health, as well as by adult, youth and family satisfaction. These are also color coded for easy reference. A copy of the 2010 report is also attached.

A major portion of the quality improvement process in Utah is based on the yearly contract monitoring audits that the DSAMH conducts with each Local Authority. These audit visits are a combination of audit, technical assistance, and performance review. These extensive reviews include on site visits, client interviews, extensive review of clinical charts and records, inspections of administrative and financial records, meeting with local stakeholders, comprehensive discussions with program managers and reviews of program schedules and policies, and discussions about progress towards meeting goals set out in the DSAMH Division Directives. A review of corrective actions taken since the last review is also an integral part of the process. At the conclusion of these 1 to 2 day visits, the Local Authority Directors are provided feedback in preparation of a formal written report that is sent to the County Government Representative for each Local Authority. As shown below, findings are graded as being Significant, Major, or Minor Findings. A draft copy of the agenda for the combined Substance Abuse and Mental Health site visit is also attached. An example of the monitoring checklist used to monitor the Substance Abuse Agencies is also attached.

An improvement in the Division's monitoring that will be implemented in FY 12 is a quarterly review of SA and MH outcomes and data. Prior to FY 11, data was submitted only quarterly, and by the time it was entered, compiled and reviewed, it was of marginal usefulness. In FY 11 all data was required to be submitted monthly, and the review time was significantly reduced. Most data can be reviewed within 60 days of the end of the quarter, and instead of reviewing data that was often close to a year old, the Division will be able to provide feedback to the Local Authorities throughout the year on their performance.

Another new addition to the monitoring process will be the implementation of a Stakeholder survey prior to each site visit, with feedback provided to the agency during the visit. The survey will examine Stakeholders and Agency partners understanding of the services provided by the Local authorities, as well as an opportunity to provide feedback on the effectiveness and accessibility of the provided services. The initial year will be limited to agencies that the Local Authorities identify as stakeholders and partners, with future years expanding that list to additional community partners and consumers.

S. Suicide Prevention

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- **Provide the most recent copy of your state's suicide prevention plan; or**
- **Describe when your state will create or update your plan.**

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans available on the SAMHSA website at here.

In fall of 2011, the Utah Division of Substance Abuse and Mental Health (DSAMH) assisted in the formation of a Suicide Prevention Coalition that meets monthly. This group is a broad coalition that includes representatives from active duty Air Force, Army and Air Force National Guard, the Veteran's Administration, Community Coalitions and groups, State Agencies and Departments, County and City Governments and citizen representatives. A copy of the most current Suicide Prevention Plan is attached.

In March of 2013, the Utah State Legislature passed House Bill 154 which requires the Sate Board of Education to do the following:

- *designate a State Office of Education suicide prevention coordinator to oversee*
- *school district and charter school youth suicide prevention programs;*

- *establish model youth suicide prevention programs for school districts and*
- *charter schools that include certain requirements; and*

- *report the progress of implementation of programs related to youth suicide*
- *prevention to the Legislature's Education Interim Committee;*

- *requires school districts and charter schools to implement a youth suicide*
- *prevention program for students in secondary grades;*

The bill additionally requires the Division of Substance Abuse and Mental Health to do the following:

- *designate a state suicide prevention coordinator*

- *requires the state suicide prevention coordinator to:*
- *coordinate suicide prevention programs and efforts statewide with multiple*
- *entities, including the State Board of Education; and*
- *report to the Legislature's Education Interim Committee, jointly with the State*
- *Board of Education, on suicide prevention programs and coordination with the*
- *State Board of Education;*

DSAMH has aggressively promoted the use of Mental Health First Aid, SQPR and ASIST across the state's Behavioral Health system and has promoted education and training to improve awareness of the extent of suicide as a problem in Utah. DSAMH has worked closely with the coalition to improve services to veterans and other high risk populations.

DSAMH will continue to expand its training and education efforts across the state system and is working on initiatives that can better identify high risk populations and develop ways to better identify individuals at risk of self harm and the system's ability to respond to those threats.

T. Use of Technology

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- **What strategies the state has deployed to support recovery in ways that leverage ICT;**
- **What specific application of ICTs the State BG Plans to promote over the next two years;**
- **What incentives the state is planning to put in place to encourage their use;**
- **What support system the State BG Plans to provide to encourage their use;**
- **Whether there are barriers to implementing these strategies and how the State BG Plans to address them;**
- **How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;**
- **How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and**
- **What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.**

States must provide an update of any progress since that time.

Effective 1 July 2013, all of the Local Substance Abuse Authorities will be using an electronic health record. The decision by the Local Authority providing Substance Use Disorder services to Cache, Rich and Box Elder Counties to convert from paper charts to an electronic Health Care Record completes the process for all SUD and MH authorities in the State. All of the Local Authorities have been providing data to DSAMH's SAMHIS system, but this will improve the ability to track data across the state.

As of July 1, 2012, all Local Authority providers are required to collect and submit to DSAMH the approved EBPs being utilized in treatment at the client level. The approved list is attached.
EBPs are to be included (listed) in the treatment plan for clients and reported to DSAMH throughout the treatment episode.

It is our intent to use this information for program and outcome evaluation. The measures looked at can be broad to include successful completion of treatment (discharge), GAF scores, OQ scores, intensity of services, retention (clients who remain engaged versus clients who do not return), etc. In other words EBPs used can be correlated with all other data collection elements for evaluation.

Evidence Based Practice List

1 = Medication Management
2 = OQ/YOQ
3 = Wraparound to Fidelity
4 = Assertive Community Treatment
5 = Supported Employment
6 = Supported Housing
7 = Family Psychoeducation
8 = Illness Self-Management and Recovery
9 = Multisystemic Therapy (MST)
10 = Therapeutic Foster Care
11 = Functional Family therapy (FFT)
12 = WRAP
13 = Mobile Crisis
14 = School Based
15 = Integrated Treatment for Co-occurring Disorder (Mental Health Substance Abuse)
16 = Motivational Interviewing
17 = Medication assisted therapy
18 = TREM
19 = Helping women recover
20 = Seeking Safety
21 = Matrix Model
22 = Beyond Tauma: A Healing Journey for Women
23 = Clubhouse
24 = DBT (Dialectical Behavioral Therapy
25 = MET (Motivational Enhancement Therapy)
26 = Prime for Life–Treatment
27 = Peer Support
97 = Unknown
98 = Not Applicable

U. Technical Assistance Needs

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?

The Utah Division of Substance Abuse and Mental Health (DSAMH) is currently receiving technical assistance with the Community Advisory Council.

2. What are the sources of technical assistance?

The DSAMH is receiving technical assistance with the Community Advisory Council from SAMHSA.

3. What technical assistance is most needed by state staff?

Technical assistance areas most needed by the DSAMH are around implementation of the Affordable Care Act, implementation of federal Mental Health Parity requirements, and with recovery support services.

4. What technical assistance is most needed by behavioral health providers?

Technical assistance areas most needed by behavioral health providers in Utah include implementation of the Affordable Care Act, billing and contracting with third party payers, implementation of federal Mental Health Parity requirements, and with recovery support services.

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [MH]

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			$	$	$	$	$
6. Other 24 Hour Care		$	$	$ 1,715,749	$	$ 4,055,935	$
7. Ambulatory/Community Non-24 Hour Care		$ 333,607	$	$ 954,634	$	$ 4,165,933	$
8. Mental Health Primary Prevention		$ 37,954	$	$	$	$	$
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)		$ 225,000	$	$	$	$	$
10. Administration (Excluding Program and Provider Level)		$ 156,441	$	$	$	$	$
11. Total	$	$753,002	$	$2,670,383	$	$8,221,868	$

* Prevention other than primary prevention

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [SA]

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment	$11,273,631		$	$6,820,922	$10,711,816	$6,105,593	$6,484,019
a. Pregnant Women and Women with Dependent Children*	$ 2,448,936		$	$ 702,668	$ 1,195,140	$ 315,879	$ 930,865
b. All Other	$ 8,824,695		$	$ 6,118,254	$ 9,516,676	$ 5,789,714	$ 5,553,154
2. Substance Abuse Primary Prevention	$ 4,023,837		$	$ 79,000	$ 80,441	$ 564,759	$ 709,601
3. Tuberculosis Services	$		$	$	$ 366,089	$	$
4. HIV Early Intervention Services	$		$	$	$	$	$
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non -24 Hour Care							
8. Mental Health Primary Prevention							
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)							
10. Administration (Excluding Program and Provider Level)	$ 805,130		$	$	$	$	$
11. Total	$16,102,598	$	$	$6,899,922	$11,158,346	$6,670,352	$7,193,620

* Prevention other than primary prevention

Footnotes:
The above are a forecast of the SA expenditures for SFY2014. At the current time, we do not anticipate any major changes during SFY2015.

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SABG Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Expenditure Category	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$ 11,273,631	
2 . Substance Abuse Primary Prevention	$ 4,023,837	
3 . Tuberculosis Services	$	
4 . HIV Early Intervention Services**	$	
5 . Administration (SSA Level Only)	$ 805,130	
6. Total	$16,102,598	

* Prevention other than primary prevention

** HIV Early Intervention Services

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Strategy	IOM Target	FY 2014	FY 2015
		SA Block Grant Award	SA Block Grant Award
Information Dissemination	Universal	$	
	Selective	$	
	Indicated	$	
	Unspecified	$ 460,956	
	Total	$460,956	
Education	Universal	$	
	Selective	$	
	Indicated	$	
	Unspecified	$ 2,400,689	
	Total	$2,400,689	
Alternatives	Universal	$	
	Selective	$	
	Indicated	$	
	Unspecified	$ 205,253	
	Total	$205,253	
Problem Identification and Referral	Universal	$	
	Selective	$	
	Indicated	$	
	Unspecified	$ 361,344	

	Total	$361,344	
Community-Based Process	Universal	$	
	Selective	$	
	Indicated	$	
	Unspecified	$ 432,051	
	Total	$432,051	
Environmental	Universal	$	
	Selective	$	
	Indicated	$	
	Unspecified	$ 163,544	
	Total	$163,544	
Section 1926 Tobacco	Universal	$	
	Selective	$	
	Indicated	$	
	Unspecified	$	
	Total	$	
Other	Universal	$	
	Selective	$	
	Indicated	$	
	Unspecified	$	
	Total	$	
Total Prevention Expenditures		$4,023,837	
Total SABG Award		$	
Planned Primary Prevention Percentage			

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5b SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Activity	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
Universal Direct	$ 1,071,877	
Universal Indirect	$ 513,345	
Selective	$ 1,684,871	
Indicated	$ 753,744	
Column Total	$4,023,837	
Total SABG Award	$	
Planned Primary Prevention Percentage		

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Activity	FY 2014 SA Block Grant Award				FY 2015 SA Block Grant Award			
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$ 40,088	$	$	$40,088				
2. Quality Assurance	$	$	$	$				
3. Training (Post-Employment)	$ 124,025	$ 63,000	$	$187,025				
4. Education (Pre-Employment)	$	$ 15,000	$	$15,000				
5. Program Development	$	$ 66,022	$	$66,022				
6. Research and Evaluation	$	$	$	$				
7. Information Systems	$	$	$	$				
8. Enrollment and Provider Business Practices (3 percent of BG award)	$	$	$	$				
9. Total	$164,113	$144,022	$	$308,135				

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2014

Service	Block Grant
MHA Technical Assistance Activities	$
MHA Planning Council Activities	$ 5,000
MHA Administration	$ 222,950
MHA Data Collection/Reporting	$ 170,000
Enrollment and Provider Business Practices (3 percent of total award)	$
MHA Activities Other Than Those Above	$
Total Non-Direct Services	$397950
Comments on Data:	

Footnotes: